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NUMBER 4

APRIL
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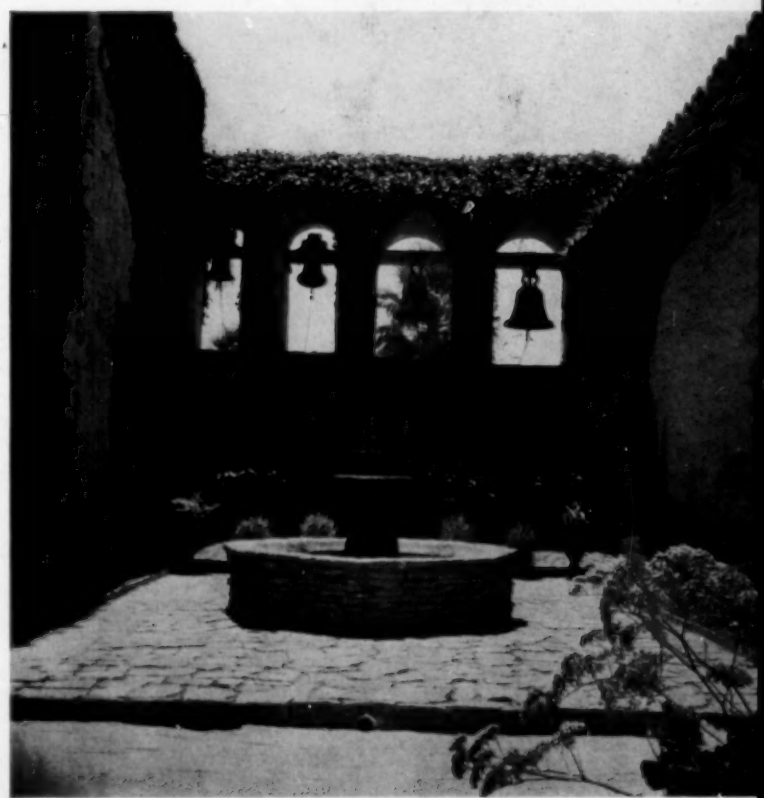
THE CANADIAN NURSE



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(1) 1939. Accepted Foods and Their Nutritional Significance, Council on Foods, American Medical Association, Chicago, Illinois.

(2) 1937. American J. Digestive Disease and Nutrition, 240.

(3) 1940. Am. J. Pub. Health 30, 169.

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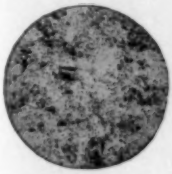

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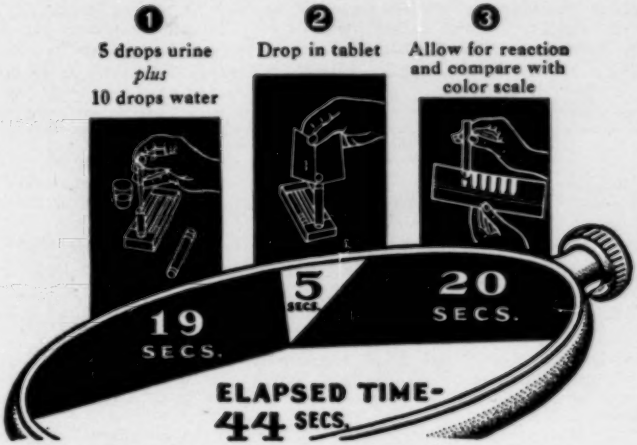

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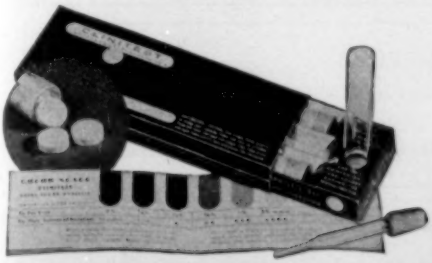

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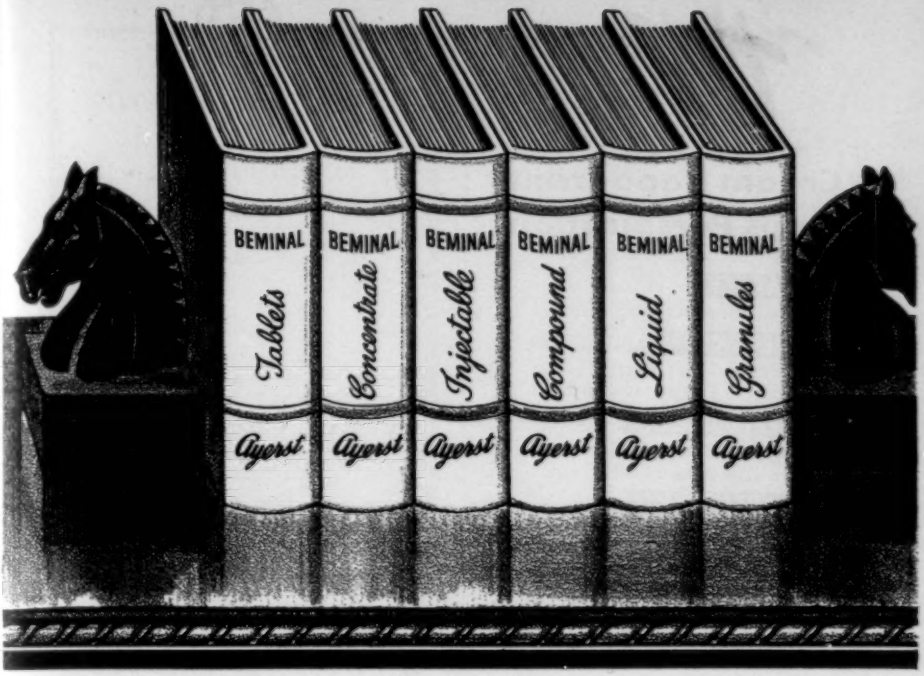

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EXAMINATION ANNOUNCEMENT

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An examination for the Registration of Nurses in the Province of Ontario will be held on May 26th, 27th and 28th.

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Flavours and Vehicles

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The Canadian Nurse

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Editor and Business Manager:
ETHEL JOHNS, Reg. N., 1411 Crescent Street, Station H, Montreal, P.Q.

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Reader's Guide

Before making any scornful remarks about the slimness of this issue of the *Journal*, please be kind enough to read **Iron Rations.** If that doesn't soften your hard heart, nothing will. After spending eleven years in building the *Journal* up, it does seem a bit ironical to devote the few remaining months of our term in office to scaling it down. Nevertheless we are determined to make the best we can out of a bad job and try to prove that good things are sometimes tied up in small parcels. Incidentally, we want to warn dilatory subscribers that in future no special consideration can be shown them. There was a time when we used to go on sending the *Journal* for a month or so in the hope that eventually the dawdlers would send in their delayed renewals, and usually they did. But don't expect anything like that from now on. Journals are at a premium these days. Don't ask us for back numbers either. There aren't going to be any. These are the days of iron rations.

We are greatly indebted to Miss Martha Watt for obtaining the excellent article on papillary carcinoma of the bladder that appears in this issue of the *Journal*. Under the direction of **Alice Cutting** six student nurses of the School of Nursing of the Hamilton General Hospital helped to prepare this comprehensive report of an unusual and difficult case. Prior to her recent appointment to the Nursing Service of the Royal Canadian Navy, Miss Cutting was head nurse in one of the male surgical wards of the Hamilton General Hospital.

The Emergency Nursing Adviser has the knack of hitting the nail on the head. If you will turn to **Some Pertinent Questions** you will find that, as usual, Miss Ellis is very much on the alert and has overheard some of the questions that float about in the air at meetings and yet somehow fail to come out in open discussion.

Conserving the health and promoting the welfare of industrial workers is of paramount importance especially in time of war. **Dr. F. M. R. Bulmer** first gives a clear and concise description of the various hazards to which the workers are necessarily exposed and then indicates the measures used to combat them. The substance of this article was delivered in the form of an address to the McGill School for Graduate Nurses. This created so much interest that permission was sought and obtained to publish it in the *Journal* so that public health nurses in all parts of Canada might have the privilege of reading it. Dr. Bulmer is the director of medical service for the Allied War Supplies Corporation.

There is possibly no disease in which the co-operation of the patient is more essential than it is in diabetes. **Helen McCallum** presents a number of eminently practical suggestions for teaching a child of ten how to assume responsibility for her own treatment. Miss McCallum is medical supervisor in the Hospital for Sick Children, Toronto.

This issue of the *Journal* contains advance notices of the **Annual Meetings** of the provincial Associations of Registered Nurses in Alberta, British Columbia, Manitoba and Quebec. Now, as never before, every nurse should make a point of attending conferences at which decisions will be made that will affect the future of nursing for years to come. It is the younger nurses who should take the most active part both in formulating new policies and putting them into practice. Have the courage of your convictions and then stand up and speak up.

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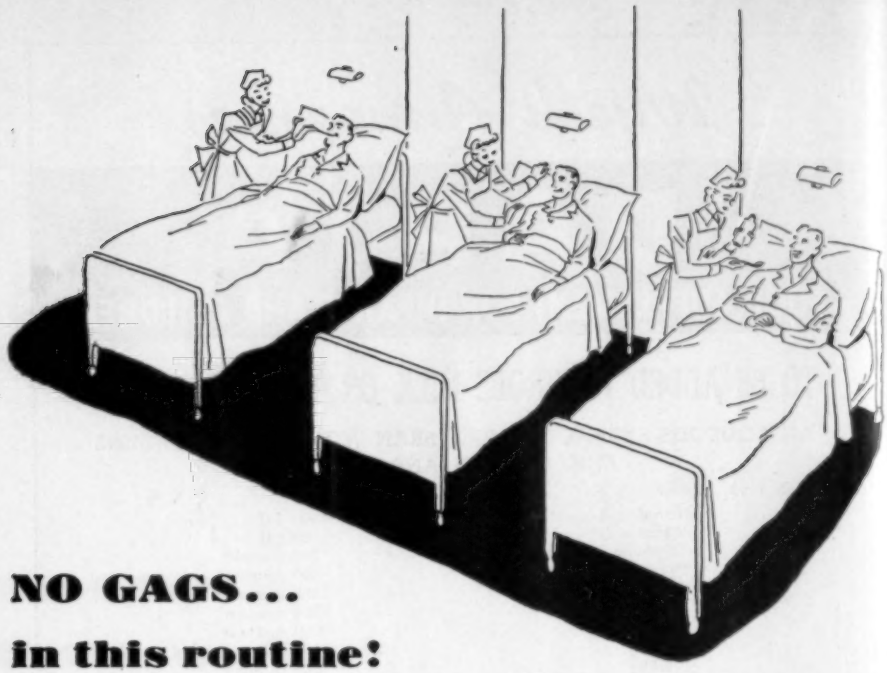

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The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION
VOLUME THIRTY-NINE NUMBER FOUR

APRIL 1943

Iron Rations

Just as the *Journal* was blossoming out into an eighty-four page magazine, and we were embarking on an active promotion campaign, the Wartime Prices and Trade Board suddenly rationed our supply of paper. This stern ruling dashed our soaring spirits considerably but it looks as though we shall just have to grin and bear it. After all, there's a war on. The immediate problem is to find out how to use our diminished supply to the best advantage. Circulation is steadily rising and it follows that we must provide more magazines this year and yet use less paper. Under these circumstances, it is evident that the *Journal* cannot maintain the progressive increase in size which has steadily been going on for some years. Some of the material now being published will have to be condensed or possibly omitted. The burning question is what to leave in and what to take out!

Before making this difficult choice, the mechanical set-up of the *Journal* has been carefully examined with a view to making the best possible use of every page. This will be a continuing process and, even in this issue, you will see that the columns are longer and that the articles have less space between them. The *Journal* won't look as nice but there will be lots of good things in it even if they are not as attractively arranged as they used to be. Unfortunately these economies will not in themselves be sufficient to effect the necessary reduction. Other possibilities must be explored and, at this point, it may be well to review the purpose and functions of the *Journal*. These were outlined and accepted in a report submitted by the editor at a general meeting of the Canadian Nurses Association held in June, 1934, and may be summarized as follows:

1. To reflect, interpret, and integrate the thinking of Canadian nurses.

2. To afford a means for dignified publicity concerning the activities of the Canadian Nurses Association.

3. To act as a stimulus toward in-

telligent study of nursing problems—professional, educational, and economic.

4. To serve equally all the branches of nursing service and to avoid narrowness and sectionalism.

5. To be of service to all Canadian nurses and especially to those who practise their profession in isolated and remote parts of our country.

6. To interpret the aspirations and ideals of Canadian nurses to nursing groups in other countries.

A selective process, looking toward the elimination of non-essentials, should be conducted with these primary functions in mind. None of them must be neglected, but only a keen sense of values can determine how best they may be carried on within the physical limitations imposed on us. One thing is certain, first things must come first. At this critical juncture in nursing affairs, and at a time when drastic social and economic changes are in the air, it is apparent that sufficient space must always be available for publicity concerning the activities of the Canadian Nurses Association. It also looks as though editorials (like the one you are now reading) may be a necessary evil. Every effort should also be made to keep the Special Pages going. These are sponsored by the three National Sections and have brought in much valuable material which otherwise might never have appeared in the *Journal*. Furthermore, these Pages have helped to express the thinking of the members of the various Sections and to develop sound and progressive leadership. If at all possible, the Student Nurses Page should be retained. These young women are the nurses of tomorrow and should be kept informed of what is going on in the strange and troubled world of nursing into which they must soon be inducted.

If all this material is to be kept in, what must be thrown out? Suppose we examine some of the well intentioned suggestions that have already reached us. The first impulse on the part of many readers is to "get rid of all that advertising". They forget that the *Journal* is required to be self-sustaining and therefore owes its very existence to the revenue derived from advertisers. Earnings from this source are greater than those derived from subscriptions and make it possible to offer the *Journal* at a price which is much less than its actual cost. If advertising were to be refused, the subscription rate would either have to be sharply increased or else the Association would have to meet a heavy deficit. Many urgent and legitimate demands are already being made on the C.N.A. treasury and further drains should be avoided until the existing crisis is over. Another suggestion is that commercial advertising should be retained and that the Official Directory should be curtailed. This alternative is now being considered by the Publications Committee and will be reported upon in a later issue. This plan would involve some loss of revenue and has other drawbacks but it may be necessary to adopt it as a last resort.

Working backwards through the book, we now come to a frivolous page for which no valid excuse could ever be found. This will automatically disappear before long to make room for something of more tangible value. Next we come to "News Notes", and here we enter on highly debatable ground. From the editorial point of view, this department is a severe pain in the neck which has to be endured in order to cater to the depraved taste of readers who like to hear about people rather than about ideas. To abolish it altogether would doubtless provoke a reaction that we shudder to contemplate. But in future the editorial blue pencil must do its deadly work and consider-

able space can be saved without sacrificing "reader appeal" unduly.

So far we have purposely refrained from mentioning the precious pages in the middle of the *Journal* known, in office slang, as "the body". It is here (when we can lay hands on such treasures) that we proudly display articles which deal with the difficult and lively art of nursing. Not nursing education, nor nursing economics, not even public health nursing. Just nursing reduced to its simplest terms —a very ill patient whom an intelligent nurse is striving to keep alive, to heal and to comfort. It is these articles which are most eagerly sought by the rank and file of our readers and yet are the hardest to come by. We have a brief for the rank and file. It is they who have kept the *Journal* going year in and year out, in good report and ill. Many of them are not themselves articulate but of them it may truly be said: "Each becometh wise in his own work. Without them shall not a city be inhabited. But they shall not be sought for in the council of the people and in the assembly they shall not mount up on high. They shall not declare instruction nor judgment. But they shall maintain the fabric of the world, and in the handiwork of their craft is their prayer".

The handicraft of their work—we wondered what that phrase recalled to us—and then we remembered. It was a meeting, many years ago, in a hot and crowded room. An eloquent platform orator was discoursing about "the House of Nursing, builded not with hands". Beside us there was a hard-bitten ancient who muttered under her breath "No, and not built without them either".

Well—we have to lighten ship! What do you think we ought to throw overboard? We have tried to tell you what we think we ought to keep.

—E. J.

A Case of Papillary Carcinoma of the Bladder

Alice Cutting

By way of introduction, brief reference will first be made to the anatomy and physiology of the urogenital tract. The kidneys lie at the back of the abdominal cavity, one on each side of the spinal column and behind the peritoneal cavity; they are bean-shaped, with concave borders directed toward the median line of the body. Near the centre of the concave border is a fissure called the hilum which serves as a passageway for the ureter, blood vessels, lymph vessels and nerves leading to and from the kidney. The kidneys are abundantly supplied with blood by the renal arteries. They take the protein waste and the greater part of the salts not needed by the blood from the blood stream, and excrete them in the urine. The ureters are two cylindrical tubes which convey the urine from the kidneys to the bladder; they are ten to twelve inches long and about one-fifth of an inch in diameter. Peristaltic contractions of the ureters carry the urine downward into the bladder. The ureters are inserted into the posterior wall of the bladder, a hollow muscular organ, lying in the pelvic cavity behind the pubes and in front of the rectum. It consists of four coats: the serous coat, a reflection of the peritoneum, covering the upper surface; the muscular coat, having three layers, of which the circular fibres form the in-

ternal sphincter; next comes the submucous coat, and then the mucous coat, which is thrown in folds or rugae when the bladder is empty. The bladder has the power to relax and contract as it is filled or emptied and, normally, a full bladder holds 400 to 500 cc. before voluntary relaxation of the external sphincter allows it to be emptied. Where there is a pathological condition of the bladder, such as carcinoma, its capacity is greatly lessened, as its elastic abilities are inhibited by the growth contracting and causing adhesions in the muscular layers.

The subject of this case study is a Canadian of English descent, born 51 years ago. His father was a furniture finisher, who appears to have moved about considerably from place to place. Hence, Mr. T.'s boyhood was disjointed and he left school when he was only eleven years old in order to go to work. If there are advantages and disadvantages in belonging to a large family (and there definitely are) our patient had them both, for there were three sons and eleven daughters. Living in close quarters with so many relatives has apparently given him an insight into how to get along with people—an inner psychology, which all his life has created happiness within the man himself—and a desire to make the best of everything, no matter what the circumstances.

Mr. T. was not trained in any special trade, but a type of apprenticeship resulted in two vocations—barbering and the machinist trade. Overwork may have been a contributing factor to his illness. From 1915 to 1940, he worked in the daytime at a machine shop, and as a barber three nights a week and on Saturday afternoons. This was done to make life easier for his wife and five children. Mr. T. has had no serious previous illnesses. However, mild symptoms leading up to the ultimate cystectomy have been prevalent since 1910, when a dull aching pain in the right inguinal region was first noticed; this was relieved by rest but lasted from 1910 continuously until March 1942, when it suddenly disappeared. A sensation as though a small piece of gravel were passing would be felt, then would cease for a short period. As the years passed, the pain began to radiate up to the kidney region and was relieved by the use of laxatives. Gradually it began to be a steady ache, but did not interfere with his work.

In 1935, the patient first noted haematuria, very little at first. He then visited another doctor who gave him an examination; the urinalysis showed pus and red blood cells. Medication was given and after a time he felt slightly improved but was still passing an occasional small amount of blood in his urine. In 1939, the first haemorrhage occurred and lasted two days. A third doctor was called and a diagnosis of renal calculi was made; medicine was prescribed, but the patient showed no improvement. A friend recommended an herb—"Queen of the Meadow", which the patient took until the time of his recent haemorrhage. From 1939 until 1942, the patient had slight haemorrhages about every four to eight weeks, which would last about two days. In March 1942, there were frequent haemorrhages, with large clots of blood which required considerable pressure to expel; this condition was accompanied by severe pain which lasted from a few days to a week or two. It was suggested that there might be a tumour of the bladder, possibly malignant.

In August 1942, the patient was seen by a physician who diagnosed the case as carcinoma of the bladder, and advised removal of the bladder. The provisional diagnosis was papillary carcinoma and was based on (1) physical signs and symptoms; (2) findings at cystoscopic examination which revealed marked involvement of the bladder, the growth extending over the right ureteral mea-

tus and the prostate gland on each side. The final diagnosis was made by microscopic examination of tissue from the bladder, which revealed papillary carcinoma. Malignant carcinoma cells appeared as short pedicules bearing a tuft of short irregular fronds, with points of adhesions where blood vessels tended to anastomose. Histological examination showed large differentiated epithelial cells perforating the basement membrane.

Due to the extent of the carcinomatous lesion the bladder, which is the reservoir of urine, had to be completely removed. To provide a new outlet for the urine the ureters may be transplanted either to the exterior surface of the abdominal wall or into the large bowel. It was decided in this case to use the second method.

Pre-operative treatment included intravenous glucose in normal saline to increase body fluids, dilute toxins in the blood stream and lessen post-operative shock; transfusion of 500 cc. citrated blood to replace blood loss in haemorrhage and to prevent post-operative shock; enteroclysis to remove all fecal material from the large bowel and facilitate working at time of operation, lessen danger of infection, and leave an empty descending colon so that urine would not be readily blocked off in the sigmoid.

A series of four surgical operations began in September 1942, with the transplantation of the right ureter. Through an incision in the lower right quadrant of the abdomen, the right ureter was freed from the surrounding tissue for some distance proximal to, and then divided at, its entrance into the bladder. The sigmoid was brought up through an opening in the posterior peritoneum and the implantation made by stay-suturing the ureter into the sigmoid and overlapping one and a quarter inches of the ureter with the serosa of the sigmoid. A cigarette drain was inserted in the incision to allow serous and sanguineous drainage to escape. A rectal tube was inserted as far as the sigmoid, to drain off the urine and prevent distention causing pain. After a period of ten days, a transplantation of the left ureter was done in the same manner as the previous operation. Sulphathiazole powder and glycerine were smeared in the left retroperitoneal space and a cigarette drain was inserted into the incision.

These transplantations were done separately, so that any defect in the function of the right ureter would be detected before the left was transplanted. Following the operation, urine was passed in small amounts by rectum as well as in the usual manner. Following the second operation, all urine was excreted into the sigmoid and passed by rectum. At first, urination was slightly involuntary, but gradually, in a few days, the patient gained complete control.

On October 15, 1942, complete cystectomy and prostatectomy were performed and the diseased bladder and prostate were removed. No drains were inserted in the incision, but a Foley catheter was passed through the urethra into the cavity left by the removal of the bladder to allow the serous and sanguineous drainage to escape. These three operations were performed through low abdominal incisions in each case, and surgery was done extra-peritoneally. Spinal anaesthesia was used in these three operations. On November 7, 1942, a bilateral partial orchidectomy was done; this operation is performed in cases of carcinoma of the prostate, as it is thought that the testicle has something to do with cancer in the male. A portion of the testicle is removed and it is believed that this procedure causes a recession of carcinomatous metastases.

The post-operative treatment included the administration of an analgesic and a mild hypnotic to relieve pain and to produce sleep. Intravenous glucose in

normal saline was first given, followed by glucose in distilled water, to replace loss of fluid during operation and to counteract shock. Pitressin was given intramuscularly every hour, for six doses, to improve peristalsis and relieve gas pains and distention caused by manipulation of the bowel during operation. Soluthiazamide was administered intravenously to counteract infection. The patient had an elevation of temperature the day after operation, and it was thought it might be due to wound infection; it was controlled in 24 hours by giving one ampoule, twice daily. Ferrous sulphate was given to restore iron content and increase haemoglobin in the blood. Following the intravenous administration of diodrast an x-ray examination was made. Diodrast is a solution which is excreted slowly and exclusively by the kidneys. Being an opaque substance, the function of the kidneys and ureters can be followed as it is excreted. The report was good, showing bilateral excretory function of the dye.

Certain complications sometimes follow cystectomy. Among these are secondaries of carcinoma metastases, direct or indirect. The direct extend from the original growth to the surrounding tissues; the indirect are those resulting from the transfer of the carcinoma cells by the blood stream or lymphatics, to any part of the body. In Mr. T's case, a gland taken for examination from the region of the bladder did not show any signs of malignant changes in its structure. A great hazard following transplantation is that of an ascending infection involving the ureters and eventually the bladder itself, caused by organisms such as bacillus coli, which are normally found in the large bowel. Anuria may be caused by an obstruction of one or both ureters as a result of oedema at the junction of the ureter with the sigmoid; a kink in the ureter or its blocking by pus may be the cause of anuria. In any of the instances, symptoms of hydronephrosis, pyonephritis, pyelitis or pyelonephritis, would be evident, either unilaterally or bilaterally. Suppression, or reflex anuria caused by shock, may also be the reason for anuria. Pneumonia is always a post-operative complication to be guarded against but no chest involvement was present in this case. Wound infection did not occur. The patient was carefully watched for haemorrhage because of the copious blood supply to the organ which had been removed. Embolism is also to be feared following an operation where large vessels are tied off.

Nursing care was important in this case. The mental preparation of the patient was comparatively easy; the doctor had explained the necessity for the operation to him previous to admission and, being a more or less stable person, he was not unduly upset. Shaving of the lower abdomen and pubes, followed by a tub bath, was done on the ward. Three colonic irrigations were done to free the colon of feces. Fluid diets were ordered for several days prior to operation, and were given generously up to 4000 cc. daily. Following each operation, the patient was received in a warm bed and placed in the Trendelenburg position (following spinal anaesthetic) for from six to eight hours. Pulse and respiration were checked every two hours for the first twelve hours. The dressing was observed frequently, noting the patient's colour and watching for signs of bleeding or symptoms of shock. The patient was placed in Fowler's position, or in any other comfortable position, after the first eight hours.

While hypodermocylsis was being carried on, a lubricating substance was applied to lips and tongue together with frequent mouth washes. Application of alcohol and powder, as well as a daily bath, kept the patient refreshed and prevented irritation of the back. Air-rings and pillows also were used to prevent pressure. An accurate record of fluid in-

take and output was kept, and fluids were forced continually. The patient was turned frequently and encouraged to move about in bed, exercising his legs as much as possible as a prophylactic measure against hypostatic pneumonia and formation of emboli. Following the second uretral transplantation, the patient was allowed up for a few days before his third operation. He was discharged November 14, 1942, seven days after his fourth operation.

Without surgical intervention this patient probably would not have lived six months. Following the third operation (cystectomy and prostatectomy), the probable length of time he might be expected to live would be two years. With the completion of the fourth operation (bilateral, partial orchidectomy), it is hoped that he may live five years or longer. After undergoing a series of operations such as this, it will be necessary for the patient to readjust himself in order to lead as normal a life as possible. It is the duty of both nurses and doctors to instruct him how to do this. Regarding diet, his fluid intake should be moderately large each day to keep the kidneys functioning and excreting well, thus keeping infection from ascending the ureters. Regular and daily evacuation of the lower bowel is absolutely essential; this is attained by a properly balanced diet containing plenty of vitamins, especially vitamins B and C, with sufficient bulky foods. Harsh cathartics should always be avoided, as violent peristalsis may damage the site of the operation. Any blood appearing in the stool should be reported immediately to the doctor. Good health habits and rules for rest should be observed so as to give the patient a better chance of longer life.

Ready for New Tasks

Very much to the regret of the Board of Directors of the Vancouver General Hospital, Grace Mitchell Fairley has asked to be released from her duties as superintendent of nurses and director of the School for Nurses. For the past fourteen years Miss Fairley has been responsible for directing the nursing service of a hospital with over a thousand beds and has guided the destinies of one of the largest schools of nursing in Canada. Even in normal times, responsibilities such as these are a heavy load to carry; complicated by the exigencies of war, they might easily have overhelmed a less competent and resourceful leader.

In paying tribute to Miss Fairley's achievements Dr. A. K. Haywood, general superintendent of the Vancouver General Hospital, writes as follows:

I first met Miss Fairley in Montreal when she was superintendent of nurses at the

GRACE M. FAIRLEY

Alexandra Hospital. We worked together during the influenza epidemic of 1918 and it was then that I first discovered her sterling character and ability. Time marched on and so did Miss Fairley — Hamilton, London — and then in 1929 she came to the Vancouver General Hospital. It was my good fortune to join forces with her in 1930 and to have her assistance and leadership in developing what everybody in the nursing world, in Canada at least, would admit is an outstanding school for nurses. This has been no small task, especially in a semi-open hospital, but Miss Fairley has risen to the occasion.

During her term of office she has witnessed rapid educational changes in the nursing world and greatly increased demands by the public in relation to nursing services. In dealing with both these problems, her leadership and advice has been widely sought. Not the least of her accomplishments has been to convince the board of directors that, in a good school of nursing, there should be a generous ratio of graduates to students. Her efforts have been crowned with success and whereas she had 50 graduates when she took over her duties here, today she has 300. To accomplish this she had at times to almost defy the board of directors, but her powers of conviction were such that she finally won. Her latest success was to convince the powers that be of the right of the nurse to be treated at least as humanely as those in the labour world and, within the last year, the eight-hour day for nurses has become an established fact.

One hates to say goodbye, but this is only *au revoir*. Miss Fairley will be remembered by her staff and students as a just judge who always tempered her justice with mercy. The Hospital will never forget what she has meant to all with whom she came in contact.

In a recent letter to a friend, Miss Fairley said: "I am sorry to give up my work during the war but I feel keenly that the women who will be in office during the reconstruction period should be preparing themselves now". Even though Miss Fairley is relinquishing her arduous task at the Vancouver General Hospital, there can be no question of her going out of office. She is so closely linked with the Canadian Nurses Association and with the International Council of Nurses that she will not have a chance to escape from the new demands that will be made on her in connection with post-war reconstruction in Canada and abroad. Those who know her best are quite sure that before long she will be light-heartedly commuting by airplane between Vancouver and points east — possibly even as far as her beloved Scotland. And so we wish her exciting voyages and happy landings.

Well Merited Recognition

Appreciation of the outstanding service given by Flight Lieutenant Nellie Josephine Enright, R.R.C., Matron at the R.C.A.F. Hospital, Dartmouth, was shown at a farewell reception marking her retirement from the R.C.A.F. Miss Enright had a distinguished war record in the first Great War and in 1915 went overseas with No. 3 Canadian General Hospital. She spent three years in France at casualty clearing stations close to the front lines and was awarded the Royal Red Cross. At the outbreak of the present war she entered the R.C.A.M.C. Nursing Service and later transferred to the Nursing Service of the R.C.A.F., first at Saint Thomas, Ontario, and later to a large airbase in Newfoundland where she served six months before posted to the Dartmouth Station. Miss Enright is a graduate of the Royal Victoria Hospital, Montreal.

Annual Meeting of the A.A.R.N.

The annual meeting of the Alberta Association of Registered Nurses will be held on Easter Monday, April 26, at the Palliser Hotel in Calgary. It is to be a business meeting for one day only.

A. E. VANGO
Registrar

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association.

Protecting the Industrial Worker

F. M. R. BULMER, M.B., B.Sc.

Most industrial diseases are caused by dusts, gases, vapours or fumes which have poisonous properties. In many cases the materials causing damage to the workers' health are not ordinarily considered poisonous and only cause trouble due to the conditions under which they are being used or to the method by which they gain access to the body. For instance, sand is not usually considered a dangerous material, yet under certain conditions it can cause irreparable damage to the lungs.

Dusts consist of relatively large quantities of finely divided particles of a size that may be carried by air currents or winds. These particles may be produced from any substance which can be broken up. They vary in size from about 150 microns to less than half a micron. A considerable number of particles of dust are so small they cannot be readily seen by the unaided eye. The smallest particle that can be readily seen by the eye is about 60 microns. Since the beginning of time dusts have been encountered everywhere, but it has been only since the development of specialized industry that they have become important from a health viewpoint. Industrial dusts can be divided into three groups: (1) the so-called harmless dusts; (2) dusts composed of definitely poisonous materials; (3) dusts which cause scarring of the lungs (fibrosis).

The so-called harmless dusts are dusts containing no appreciable amount of free silica or other poisonous materials. Limestone is a good example of a so-called harmless dust. Such dusts, however, are not without some harmful action. Heavy concentrations irritate the nose and throat mechanically, producing inflammation with its resulting swelling of the lining membranes of these and adjacent organs. This condition favours the growth of bacteria and the individual is more likely to have colds which may be of a serious nature. The openings into the throat from the sinuses and from the middle ear may become plugged resulting in sinus trouble and middle ear disease. The concentration of dust necessary to produce this effect is heavy and at the time of breathing causes discomfort to the worker. During such exposure a worker will usually wear a respirator for comfort as well as for protection.

Poisonous dusts are often produced in industry when poisonous materials are being processed. Probably the most common and one of the most poisonous materials used in industry is lead. Lead and lead compounds may enter the body by three avenues—by absorption through

the skin, by ingestion, and by inhalation of lead-containing dust. Absorption of lead through the skin is likely to occur only when such compounds as tetraethyl lead are handled. Fortunately these compounds are seldom used in industry. Ingestion of lead by mouth usually results from eating food containing lead, or from practising unclean habits when working with lead. When lead is ingested by mouth and swallowed, the greater part is never absorbed from the intestines into the body. The more soluble the lead compound is in the intestinal fluids the more it will be absorbed into the body. Poisoning by ingestion of lead is not common in industry.

Inhalation of lead-containing dust is responsible for nearly all the cases of lead poisoning which occur in industry. Irrespective of its chemical composition, the lead dust breathed into the lungs is absorbed by the blood stream and circulates through the whole body. The chemical composition of the lead compounds in the dust is therefore not of much importance. The important consideration is the actual amount of lead in the air being breathed. Two or three mgs. of lead dust breathed daily over a period of time will usually create changes in the body. As there are over twenty-five thousand milligrams in an ounce, you may appreciate the small quantity of lead dust which can produce trouble. In lead exposures the worker does not see, nor is he necessarily conscious, that he is breathing dust. There is no special irritation of throat or nose and the lungs are not appreciably affected.

The lead entering the blood stream circulates around the body damaging many organs. It is either excreted in the urine or faeces or in part stored in the bones of the body. The fact that lead is stored in the body makes it a cumulative poison. For this reason it is possible to have very acute cases of poisoning among workers who are exposed to very small amounts. This fact also accounts for cases of lead poisoning occurring in workers who have not been exposed to lead for years. As long as the lead is stored in the bones no trouble will occur. However, if this storage system breaks down the lead will be thrown into the blood stream and poisoning may result. Factors which are likely to cause breakdown in storage are: fever, changes in diet, certain drugs, and alcoholic intoxication. Thus, when a lead worker has an attack of influenza he may at the same time suffer from lead poisoning. Very often, lead poisoning is domestic in origin. Considerable attention has been drawn to cases of lead poisoning, often fatal, in children who have eaten lead paint from toys, verandah rails and other sources. Materials with which children come in contact should never be coated with lead-containing paints.

Arsenic Poisoning: Arsenic-containing dusts are occasionally met with in industry. While arsenic has a widespread reputation as a poisonous material, its use in industry is not attended with nearly the trouble that accompanies the use of lead. It has, however, in addition to its general poisonous properties, a tendency to cause skin trouble and to erode the partition of the nose.

Cadmium Poisoning: Cadmium is another poisonous material which is being used increasingly in industry. Operations which involve the handling of cadmium or its salts require special attention. Cadmium dust and cadmium fumes are very injurious to the lungs and even minute quantities when breathed are likely to set up lung changes of a serious nature.

Silicosis: Dusts which produce scarring of the lungs are receiving considerable attention today. Such dusts are composed partly or wholly of silica (silicon dioxide.) The disease produced is called silicosis. Quartz and flint are practically

pure silica. Granite is about one-third silica, and many other rocks and sands contain it in varying amounts. Exposure to silica dusts occurs in industry at such jobs as mining, quarrying, stone-cutting, moulding, grinding, and sand-blasting. With the exception of sand-blasting, where the dust concentration may be very high, silicosis is produced only after many years of exposure. Sand-blasters when not protected develop the disease in two years or more. Not all those exposed to silica dust develop the disease in the ordinary span of life.

In gold mining the gold is usually found in a quartz vein, and in coal mining it is the silica in the rock about the coal seam that causes trouble. Moulders get their silica exposure from sand and from the parting material used. Fortunately during the last few years non-silica partings have been developed, and have largely displaced the silica parting in the industry. The sand-blaster gets his silica exposure from the sand used for abrasive purposes. Grinders get their exposure from the sand adherent to the casting being ground or from the use of natural grindstones. Fortunately, however, most of the grindstones used in industry are made artificially and do not contain silica.

Silica dust in the air must be of a certain size before it can enter the lungs. Particles of dust big enough to be seen with the naked eye never reach the important lung substance. The particles of silica that cause silicosis are less than ten microns in size. The small particles of dust causing silicosis do not settle out of the air readily but stay suspended in it for a long time. It is a good rule to remember that where visible dust is present it is reasonable to conclude that much fine dust is present in the air. Sometimes when no visible dust is present the amount of fine dust present may be high, but this situation is rather unusual.

The first symptom usually noted by the silicotic is shortness of breath on exertion. This shortness of breath gradually increases until the individual is short of breath even while resting. This last condition, however, is rarely encountered, as most silicotics get tuberculosis before they have severe disability from silicosis and they die from the tuberculosis. Tuberculosis is so commonly the cause of death in silicotics that, at the present time, the problem of silicosis is largely one of tuberculosis. The silicotic lung, when infected with the bacillus of tuberculosis, has no power of resistance, and as the tubercle bacillus is ever present in the community, the silicotic has little chance to escape it. Most of the people who are dying today from tuberculosis and silicosis would die of old age before their silicosis alone would give trouble.

Poisonous vapours and gases can for convenience be divided into four classes according to the way in which they make their presence known: (1) those vapours or gases that cannot be smelt nor seen and that are not irritating; (2) those that draw our attention by their appearance, that is, those that can be seen; (3) those that make their presence felt by irritating action; (4) those that make their presence known through our sense of smell. In the first group are carbon monoxide, hydrocyanic acid, mercury vapour and many other materials. There is little trouble from carbon monoxide in industry, although the potential exposure is great. This is due to the common knowledge regarding the toxicity of this gas and to the adequate precaution taken to control possible exposures. Hydrocyanic acid gas or prussic acid is the gas largely used for fumigation, in which connection it has caused many deaths. It is evolved when cyanide materials are mixed with acids. In industry cyanides are used largely in the process of electro-plating. To my knowledge, no deaths have occurred in our country due to their use in this pro-

cess. This is largely due to the skill and knowledge of the electro-plater, who knows his business. Mercury vapour is given off from metallic mercury. As little as one milligram breathed daily over a period of time will cause poisoning.

In the second group, the most important vapours that attract our attention by their visibility are nitrous fumes. Nitrous fumes are brownish to black in colour. They may be evolved wherever nitric acid is used. Materials like celluloid, gun cotton, etc., when slowly burnt or oxidized give off these fumes. Solutions of nitrites as used in dyeing cotton may, under certain conditions, give off these fumes. Oxides of nitrogen, while slightly irritating, can be breathed in fatal concentration without much discomfort. Of all the poisonous fumes these are the most insidious; no trouble is usually experienced until some hours after the exposure. The result is often fatal and the true cause of death is seldom ascertained.

In group three are those gases that are extremely irritating, such as ammonia, sulphur dioxide, and chlorine. While these gases are toxic in small concentrations, their irritating effect is so great that no one would voluntarily enter or remain in a room which contained a dangerous concentration. When death occurs from these gases the cause is usually an accident; a pipe or a container breaking in a confined space and producing a lethal concentration in the air before the occupants can escape.

In group four are many vapours and gases that can be recognized by smell. All solvents, diluents and lacquers, cleaning fluids used by dry cleaners, paints, rubber cements, and many other products, contain volatile substances which can often be recognized by the sense of smell. In the case of lacquers, there is usually a mixture of volatile substances making exact recognition by smell difficult. Many of the substances in this group have anaesthetic properties when inhaled in high concentration, and will put one to sleep promptly. It is obvious that a concentration high enough to produce anaesthesis is only encountered in industry as an accident. It is the small amounts inhaled, without apparent trouble, day after day, which constitute a serious industrial hazard.

In this group are benzol, trichlorethylene, carbon tetrachloride, gasoline, hydrogen sulphide, arsine, phosgene, and many others. Benzol or benzene must not be confused with benzine, the petroleum product. Benzol is produced as a by-product in the destructive distillation of coal. It is a coal tar product. It is often a constituent of rubber cements, leather dope, and cements and paint removers, and may be present in lacquers, thinners, and many other preparations. Benzol poisoning in industry usually occurs from the repeated breathing of small amounts of benzol day after day for a long period of time. Men exposed daily to concentrations as low as 100 parts per million parts of air are likely to be injured. Benzol destroys those organs in the body that manufacture blood. The disease is very insidious, the workman seldom complaining before he is fatally poisoned. The real cause of death is often missed as the terminal illness is usually a chest infection. It is the continuous exposure to small amounts of benzol that causes trouble, not the occasional heavy exposure.

The use of trichlorethylene and of carbon tetrachloride in industry is increasing. Both these materials are used in dry cleaning plants. Trichlorethylene as a degreasing agent is finding a real place in industry. Carbon tetrachloride is sometimes used in rubber cements. Both these substances are non-inflammable, and both under certain conditions break down into phosgene, a very poisonous gas. The vapours of both substances are much heavier than air. Carbon tetrachloride in moderate amounts

causes stomach trouble and probably some liver damage. Both these substances are very volatile and quite expensive, and means for the recovery of the vapours are used for economic reasons. Experience and research suggest that carbon tetrachloride is more toxic than trichlorethylene.

Gasoline and similar petroleum compounds, although largely used, do not seem to create a serious health hazard in industry. In high concentration gasoline vapour will cause anaesthesia and death, but such concentration only occurs as an accident. Gasoline containing tetraethyl lead should never be used in industry. Its use for the automobile has not been attended with any trouble.

Hydrogen sulphide in low concentration has the odour of "rotten eggs", and in higher concentration, an irritating effect. It is frequently present in the chemical laboratory. Dangerous concentrations of this gas may occur in tannery vats, fat rendering plants, glue factories and sewers. Its toxicity is about the same as hydrocyanic acid, but its smell and irritating effect give some warning. Sore eyes are common amongst people exposed to low concentrations of hydrogen sulphide.

Arsine is a gas having an unpleasant garlic-like smell. It is very poisonous. The gas itself is not used in industry, but may be produced as an unwanted by-product. When acid is applied to metals to form hydrogen, arsine may be evolved in dangerous amounts if the acid or metal contains even traces of arsenic. It is also produced by the action of water and dilute acids on metallic arsenides and by many other chemical reactions. Two forms of poisoning occur, acute and chronic. In both types blood destruction takes place. In the acute variety the destruction is so rapid that the debris causes trouble. In such cases the mortality is about 30 per cent. In the chronic variety the destruction of blood is very gradual, and affected workers as a rule do not complain until 40 or 50 per cent of the blood has been destroyed. In chronic cases recovery is the rule if the individual is removed from exposure in time.

Phosgene or carbonyl chloride is a very poisonous gas. It is used in the synthesis of organic chemicals. It is a war gas and is classed as a lung irritant. Phosgene may be produced when certain chlorinated hydrocarbons, such as carbon tetrachloride, are decomposed by heat. The gas in higher concentrations has an irritating effect. In low concentrations it has a musty odour. Concentrations which have no irritating effects may cause serious poisoning. The lungs are affected, the trouble coming on several hours after exposure. Its action in this respect is similar to that of nitrous fumes.

Industrial diseases are usually caused by the breathing of dangerous dusts, fumes, or gases. The responsibility for their prevention or control belongs to the employer rather than to the employee. Very often a non-poisonous material can be substituted for a poisonous one without affecting the product. Thus few lacquers or enamels sprayed contain benzol or an appreciable amount of lead. Non-silica parting has largely displaced the silica parting formerly used by the moulder. Unfortunately, however there are many industries which must use poisonous materials and it is unfortunate, but nevertheless true, that some of the most useful materials have harmful potentialities. To prohibit the use of these materials would be just as unreasonable as to close down factories because of accidents, or to stop the use of the automobile because of the dangers inherent in its use.

Manufacturers should know the chemical nature of the materials used. Much of our past trouble has been due to the use of dangerous materials in industry when neither the employer nor the employee was aware of the chemical

composition of materials being used. This situation has been greatly improved by compulsory labelling under the Factory Act of all materials containing benzol and of all spray painting preparations containing lead.

New Methods: New methods of handling or treating materials may sometimes cause trouble. It is always advisable to find out the possible hazard when considering a new process or before changing a process that has been used with safety for some time. A slight variation in the treatment of materials may make a safe process very dangerous. If materials are being used that are toxic in nature, the prevention of industrial diseases can only be accomplished by a definite programme of control. Such control measures will naturally vary according to circumstances. In general, they involve methods of handling materials, ventilation, segregation of dangerous processes, the use of personal protective equipment, cleanliness, nutrition of workers, and medical control measures.

Handling: Handling of the dangerous material should be conducted in such a manner as to produce a minimum production or dissemination of dust, fumes, gas, or vapour. In general, this is accomplished by the use of enclosed systems of processing, wet methods instead of dry, low temperatures instead of high, changes in the methods of processing, such as brush painting instead of spraying, and the use of vacuum cleaners instead of dry sweeping. If enclosed systems are used under increased pressure, the danger is always greater than if a reduced or atmospheric pressure is maintained in the enclosure.

Ventilation: If possible, local exhaust equipment should be used at all points where dangerous materials may escape into the workroom. Examples of local exhaust equipment to control specific hazards are the spray booth, hoods, chrome plating tanks, and exhaust grinding wheels. When local exhaust is not possible general ventilation is indicated. This usually means that a much larger volume of air must be handled to control the hazard. General ventilation to control a specific hazard is expensive because it entails heavy heating costs in the cold weather. It is commonly used when bulky objects, such as automobiles or aeroplanes, are sprayed. Processes using dangerous materials should always be segregated so that a minimum number of workers are exposed.

Personal Protective Equipment: Personal equipment such as respirators, special clothing, gloves, goggles, protective cream, etc., may be required. Care should be taken to obtain the right equipment for the hazard in question. Cleanliness, both plant and personal, should be practised. Workers should wash carefully at the end of each work shift. Under certain conditions daily showering is necessary. A regular programme to provide clean work clothes is advisable when toxic materials that can be absorbed through the skin are handled. A double locker system, one for street clothes and one for work clothes, is often desirable. Nutrition of workers exposed to poisonous materials requires special attention. A well-balanced diet is advisable. An inadequate diet lessens the worker's ability to detoxify poisonous materials. Food should never be eaten in a workroom where poisonous materials are present.

Medical Control: Control methods start at the time of employment and continue as long as the worker is exposed to toxic materials, and usually for a period after his removal from contact.

The pre-employment examination is primarily used to select workers who are physically capable to do the required work. When toxic materials or skin hazards are present, the pre-employment examination must weed out susceptible individuals. Workers who are already suffering from chronic illness,

or those who present blood pressure changes or poor blood pictures, are not acceptable. Workers employed to handle toxic materials should be in good health. However, defects such as hernia are not important, and in some instances older workers may be preferable to young men. It is important to appreciate that a person may be undesirable from an accident viewpoint and suitable for contact with toxic materials, and vice versa.

After employment definite control methods are necessary for the worker exposed to toxic materials. These methods embrace education, inspection, periodical examination, dispensary service, and record-keeping. The worker should be instructed what he should do to prevent intoxication. Too much information regarding symptoms is undesirable, as it leads to self-diagnosis. The worker should understand that he can report to the medical department at any time he considers his health is being affected. It is important that when he does report he is treated with consideration, even if his visit was unnecessary. Frequently the industrial physician or nurse discourages workers from reporting minor troubles. Often the plant doctor or nurse is not familiar with the materials and processes used in the factory.

The plant physician and industrial nurse should make regular inspections of the factory. During such trips they should talk to the workers and show interest in their well-being. This inspection work is a sort of walking clinic in which a closer relationship is obtained between the workers and the medical department. While in the plant the general appearance of the workers, whether personal cleanliness is practised, and whether the company is doing its part in keeping the working environment in a satisfactory condition, can be noted. Changes in plant methods and material should be discussed with the officials in charge of production. If interest is exhibited during such visits, production management will soon consult the medical department when changes in materials or methods are contemplated. Particular attention should be paid to the facilities provided for personal cleanliness.

Periodic examinations will vary to a certain extent for each toxic substance. However, this variation is not as great as one would expect. If control methods are to be effective, they must detect impending trouble before illness or disability takes place. Very often specific signs are too late. In general, the periodic examination should be kept simple and short. Frequent simple examinations are more valuable than detailed examinations at long intervals. Changes in the individual or the group under consideration from time to time indicate the trend which no single individual or group examination can supply. The examination should include a general inquiry into health, weight, pulse rate, temperature, blood pressure, and a hemoglobin determination. Workers showing abnormal findings are singled out for further investigation. Much of this initial examination can be done by a nurse under a physician's supervision. This is important, as it may be necessary to check many workers at short intervals. The frequency of the examination will depend on the type and degree of exposure. In extreme instances it may be necessary every day. As a rule it is done at much longer intervals, two weeks, a month, or a year. Specific tests are sometimes of value. Stippled cell counts can be used with great success to control sickness from lead and to evaluate the degree of exposure. The counts from a group of exposed workers give more information regarding working environment than the examination of the air for lead. The white blood count in benzol exposures is important. Changes in the count will occur long before the worker realizes he is ill. Reduction in

hemoglobin is a constant and early finding in arsine poisoning. Silica exposures produce a specific type of fibrosis. It occurs somewhat late. Carbon monoxide forms a specific compound with hemoglobin.

Dispensary facilities for the care of minor illness as well as accidents should be provided in plants where toxic materials are used and the workers encouraged to report any illness, whether it be considered occupational or not. It is important for the medical departmen to have the complete confidence of the worker. This can usually be obtained by rendering service for minor illness, or in some instances by providing total medical care. The medical department should know if an exposed worker is taking outside treatment. Workers taking "arsenicals" or "sulpha" drugs should not come in contact with toxic materials. Such treatments may be the deciding factor in precipitating a toxic episode. It must be appreciated that a worker exposed to toxic materials may have a lessened tolerance for other chemicals, such as drugs and alcohol. By looking after minor illness self-medication will be largely prevented. A good dispensary service permits the worker to have easy contact with the medical department, and keeps the medical department informed of what is happening between periodical examinations.

Records are of real value. No medical control scheme can function properly without an analysis of work done. The individual, the group, and the whole plant should be followed from one examination to another. Particular attention should be paid to dispensary visits. These visits should be classified according to the place of work, type of exposure, and the most important sign, symptoms or complaint registered by the workman at the time of his visit to the dispensary. If attention is paid to minor illness and complaints, serious outbreaks of occupational sickness can be prevented. All the serious outbreaks of occupational illness that I have investigated have been preceded by an increase of complaints and minor illness, and could have been prevented if these warnings had been heeded. A study of absenteeism is important, especially the short-time absences.

Ontario Public Health Nursing Service

Winifred Walker (Toronto Western Hospital and University of Toronto public health nursing course) has accepted a position with the newly established health service in the towns of Milton, Georgetown and Acton in Halton County. Miss Walker has been supervisor of the nursing service, Teck Township (Kirkland Lake) Board of Health for several years.

Mrs. Evelyn S. Levinne (Beth Israel School of Nursing, Boston, and University of Toronto public health nursing course) and *M. Aileen McLean* (Toronto General Hospital and University of Toronto public health nursing course) have joined the nursing staff of the Health Department of East York Township.

Phyllis Bronson (diploma course, University of Toronto School of Nursing) has resigned from the East York Township Nursing Service to accept a position with the Public School Health Service in Ottawa.

Elizabeth Law (Hamilton General Hospital and University of Toronto public health nursing course) has been appointed to succeed *Mary Thom* of the Galt Board of Health.

Gertrude Tucker is now Senior Nurse with the Oshawa Board of Health Public Health Nursing Service.

Margaret Nealon (St. Michael's Hospital and University of Toronto public health nursing course) has accepted an industrial nursing position in Toronto.

Some Pertinent Questions

At one time or another in the past few months the following questions have been asked. If you have better answers than those suggested, why not forward them to the Emergency Nursing Adviser of the C.N.A.? They will be received with appreciation.

How would you answer the old imponderable — Is there a shortage of nurses? A study made not long ago showed that on November 20, 1942, there were 986 vacancies for nurses reported in Canada. A statement from all registries revealed the fact that 1133 nurses were on call on the same day. We do not know what a statistician might make out of these figures, but we do know that certain hospitals and some public health organizations are carrying on with very greatly reduced nursing staffs, while others have closed their doors because of lack of personnel, nursing included. So long as these conditions persist, we must say that there is a shortage of nurses in certain vital services.

What has created the shortage? It may be well to await more detailed information before making any further statement on this question. Since the outbreak of war nurses have gone into the Navy, Army and Air Force and into industry, but in December 1942 there were approximately 1950 more registered nurses serving the civilian population in Canada than in December 1939.

What steps have been taken to arrive at a more accurate analysis regarding shortages? The survey of nursing being undertaken by the Canadian Medical Procurement and Assignment Board is one yardstick that was mentioned in the last issue of the *Journal*. As one of the groups participating in the National Health Survey, nurses hope to learn much more about the fields in which they serve, the needs and so forth.

From the registration of nurses by National Selective Service on March 17, 18 and 19, it is hoped to obtain very accurate information regarding the supply of nursing service . . . Where it is . . . what it is . . . and what we as nurses can do, individually and collectively, to bring about more effective distribution.

How will these studies affect the individual nurse? There is no preconceived plan of action; no doubt this will depend largely on the facts revealed. Nurses are only one of the groups participating in the National Health Survey, but nursing touches them all:—medicine, hospitals, dentistry, public health, industry. In all these fields the nurse plays a vital role. Each day the possibility of a new questionnaire looms up as a means of exploring some fields that have not yet been touched.

What steps has the General Nursing Section of the C.N.A. taken to meet the present crisis? Read "Resolutions for the New Year" written by the chairman of the Section, which appeared in the January 1943 issue of the *Journal*. After doing so, you will be convinced that this group of nurses stands ready to serve as the first line of defence.

What are the latest reports on salaries and hours of duty for nurses? The difficulty of standardizing either on a national basis has long since been realized, but the trends are definitely towards better things. Salaries for nurses have gone up in all parts of Canada, and hours of duty are being reduced when available numbers make this possible. One recommendation from the General Nursing Section of the C.N.A. suggests $85. per month, plus one meal while on duty, plus laundry, as a fair salary for nurses on temporary relief duty; this on an eight-hour basis, with one day off each fortnight.

When the war is over what will be

the fate of the married nurse? Possibly a number will continue nursing; others will gladly return to take up home ties that have been rudely interrupted. No doubt the value of home-makers will be reassessed after the war is over. We can almost visualize a compulsory registration of them. They will be in great demand. It is hoped that very honourable recognition will be given to the outstanding contributions that married nurses are making in the present crisis.

What place will the auxiliary worker have in the future? The V.A.D.'s have committed themselves to retire from the professional field unless they enter it as graduate nurses. The non-voluntary nursing aide is not a war-time innovation. She has long played an important role in the care of the sick and others in the community. War has claimed for her the recognition that is her due. We hope that in the near future a place for the auxiliary worker will be found under the guidance of professional organizations in each province. The licensing of all who work for the sick for hire is not a new concept, if a less visionary one than formerly.

What of the increased number of nurses in Canada after the war? Schools generally are increasing enrolment and it looks as if there will be a material increase in the number of graduate nurses. However, during the past ten years there has been an increase in employment of over 3500 graduate nurses in hospitals alone throughout Canada. The demands for nursing health service in public health fields have also increased. Industries have opened their doors much wider to nurses. The growing popularity of health insurance schemes is evidence that the demand for hospital and community nursing service will not diminish. Nurses, too, will be needed to assist in the programme of reconstruction, not only in our own country, but in other lands. The nurse who prepares herself today for the future, who finds her niche now, will certainly be needed for some time to come. Possibly "the floater" will still float, but not as easily as she does at present. This is the time to set a charted course towards an unknown future.

Will Government Bursaries be available in 1943? It is expected that they will. Although an announcement cannot yet be made, the Canadian Nurses Association has made an urgent application to the Federal Government for a further grant this year. The value of the help given through bursaries awarded last year has been recognized by governmental authorities. It is expected that this assistance will be renewed. Make your plans early and watch the *Journal* for further announcements. This may be *your* lucky year. Remember, too, that most of the provincial associations of registered nurses offer assistance in some form to take post-graduate work.

Listen to this one! Why are Canadian nurses asking for labour exit permits to leave their country at a time of crisis? To join the Armed Forces in the U.S.A., they like them young—under twenty-three years; because Great Britain is calling for civilian nurses, and there are those who feel that her need at the moment is much greater than ours; to take post-graduate courses not available in Canada—there are several; because in some centres in Canada married nurses are still not accepted on an equal basis with single — they are in the United States; because some married nurses live near the border, where part-time duty is urgently needed—on the other side. And, we must admit, however reluctantly, because opportunities, including salaries and hours of duty, are better in some other countries; and because the infection of "accursed mobility" is prevalent in the profession.

Why are potential student nurses seeking admission to the United States? Because some of them claim that stan-

dards of education are lower in schools in the United States than they are in Canada . . . we cannot accept that one! Because it is stated that certain schools in Canada discriminate against local applicants who are accepted fifteen miles away—across the border—and because applicants of certain religious faiths cannot be appropriately placed in Canada.

Will reports from the special studies be available for the Annual Meetings of the Provincial Associations? This is doubtful, but many questions of the utmost importance will be discussed at the forthcoming meetings. Every nurse who can do so, should be there to take part in the discussions and in decisions that undoubtedly will affect the future of nursing.

Does your profession mean this much to you? An annual fee paid promptly; attending at least nine professional meetings in the year; accepting the responsibility of supporting the work of even one special committee; the courage and determination to put nursing on the map as an essential war service; faith in our leaders and active support of war efforts. We believe that it does.

KATHLEEN W. ELLIS
Emergency Nursing Adviser
Canadian Nurses Association.

A Fine Record

In January of this year, Miss Cecil Dawkins completed twenty-nine years of devoted service to the mothers of Montreal. A New Zealander by birth, in her early twenties she sailed for England and, having decided to become a nurse, applied to and was accepted by the Liverpool Nurses Training School, which was connected with the Liverpool Royal Infirmary. On completion of a three years course, she entered the Liverpool Lying-In Hospital for additional training in obstetrics and obtained her C.M.B. certificate. Wanting to see more of the world, she was undecided whether to go to South Africa or Canada but the latter country was favoured and she came to Toronto. Her first nursing post was with the Victorian Order of Nurses under Miss Eastwood and, following this, she did hospital duty in Thessalon, Ontario, for a year. Then she came to Montreal and worked for several years with Miss Lynch, who was then district superintendent of the Montreal branch of the Victorian Order of Nurses.

In 1914, she was appointed to the Nursing Staff of the Montreal Maternity. Her duties consisted of visiting the post-partum patients in their homes, and assisting in the prenatal clinic in the hospital. When the Montreal Maternity was amalgamated with the Royal Victoria Hospital in 1926, she became supervisor of the out-patient department in the Women's Pavilion. Her dauntless energy, her even temper, her devotion to duty, and above all, her unswerving loyalty, have always been a guide and comfort to her co-workers. She retires with the esteem and good wishes of the medical, social service, and nursing staffs of the hospital she served for so many years. ——C. V. B.

Photo by Garcia

CECIL DAWKINS

HOSPITALS & SCHOOLS *of* NURSING

Contributed by the Hospital and School of Nursing Section of the C. N. A.

Teaching the Diabetic Child

HELEN MCCALLUM

Today we are to outline a teaching plan for Mary B. ten years of age, admitted with a diagnosis of diabetes mellitus. This patient is assigned to Miss M. who will be responsible for the greater part of the teaching, but since we are all interested in this problem it was chosen for this conference period.

This disease as you know is due to a lack or insufficient supply of insulin, produced by the islets of Langerhans in the pancreas, to utilize the carbohydrates in the body. Under ordinary circumstances the carbohydrates are used by the muscles for heat and energy, or stored in the liver as glycogen. Failure to utilize the sugar normally causes it to accumulate in the blood in great quantities. This is why Mary's blood sugar on admission was 296 mgms. per 100 cc. instead of being within the normal limits 80-120 mgms. per 100 cc. The blood carries the sugar to the kidneys where a large amount is excreted in the urine, hence we find Mary's urinalysis showing a 4 plus sugar. This sugar irritates the kidneys and consequently has a diuretic action so we understand why Mary for the past six weeks has suffered from frequency, or polyuria. The concentration of sugar in the blood increases thirst which is known as polydypsia; this our patient also demonstrates. With failure to utilize the sugar there is an increase in appetite or polyphagia, combined with a noticeable loss in weight. Although Mary has eaten a great deal in the past six weeks she has lost ten pounds in weight. Since the body is deprived of its main source of energy, we find that Mary during this period has been tiring easily. With consistent failure to utilize sugar the body is unable to utilize fats. These accumulate in the blood stream in the form of acetone bodies and also excreted by th kidneys. Mary's urine shows a 4 plus acetone. This accounts for the drowsiness of this patient on admission and the fact that she was in acidosis, but not unconscious.

To revert to our teaching plan — this child during her probable three weeks stay in hospital must be taught to assume responsibility for herself. This is a disease she will have throughout her life and only through her own efforts and our direction, combined with her parent's supervision, will she be able to maintain a normal healthy life. This life will be dependent on her respect for diet, insulin, exercise.

1. *Teach her to understand her disease*: Compare her body, food and insulin with a fire, wood and a match. The fire will not burn without wood

and the wood must be ignited by means of a match. Similarly the food will not burn in her body without insulin and, due to diabetes, her body is unable to produce its own insulin. We are able, however, to give her this substance by means of a syringe and needle, and then the food will burn. The wood fire may be interfered with by wind or rain. The fire in her body may also be interfered with by illness or overheating. Illness cannot always be avoided but overeating can. This insulin she receives is in carefully measured amounts to burn up a carefully measured amount of food.

2. *Diet*: Explain to Mary that her food has all been carefully weighed, and that before she goes home we will send her down to the diet kitchen to learn how to do this herself. She must always be very careful to eat only the foods contained in her diet. In this way all the symptoms of illness which she now has will disappear and she will feel quite well again. Stress the regularity of her meals, breakfast at 8 a.m., dinner at 12 noon, and supper at 6 p.m.

3. *Insulin*: For the first few days explain just what this is and the reason for giving it, emphasizing the fact that it is carefully measured to burn up the food which has also been carefully measured, that it is given exactly ten minutes before each meal, but before going home the noon dose will be eliminated and she will receive it only before breakfast and supper. When the initial fear of the injection has passed, encourage Mary to give the insulin herself. Explain why you alternate the area chosen, using first an arm then a leg, then the other arm and then the other leg. Explain asepsis and the reason for gently massaging the area afterward. As soon as Mary is allowed to be an up-patient she may be taught to sterilize the equipment. This is done by means of a saucepan into which is placed an ordinary sieve. The syringe is separated, placed in the sieve, and boiled on the stove for 5 minutes. The needle is placed in the sieve and boiled for 2 minutes. The syringe and needle may be easily removed by lifting up the strainer, emptying the water from the saucepan, then putting the parts together, holding the syringe and the needle by the top. In this way no forceps are necessary.

4. *Urinalyses*: Explain why you are collecting a specimen of urine every two hours. When Mary is allowed up, she may be shown the Benedicts test for sugar. When she goes home, she will test a twenty-four hour specimen and if that shows sugar she must test specimens every two hours to find out which contain sugar and to report the information to her doctor.

5. *Exercise*: Find out the activities she is interested in; she will be able to carry on with them when she leaves the hospital, only being careful to stop as soon as she feels tired. If she continues when fatigued the insulin and diet will not balance. Enquire about the school she attends, if it is far distant it may not be advisable to come home at noon and a school lunch will have to be planned.

6. *Insulin reaction*: Due to the fact that she is a growing active girl there may be times when the insulin given may prove too much. This will be characterized by irritability, dizziness, drowsiness. If she feels any of these symptoms she may take an orange or two lumps of sugar. She may carry two lumps of sugar at all times in her pocket and take them during school hours if necessary.

7. *Coma*: There may be times when, due to illness or improper balancing of diet and insulin, there will be too much food for the insulin to utilize, then symptoms will recur, such as she had when coming into hospital. The first symptom will be consistent sugar in her specimens; if this is checked with her doctor further symptoms will be controlled. Be careful in teaching this child the symptoms of insulin reaction and coma to emphasize only the early symp-

toms. It is not necessary to frighten her unnecessarily by informing her of unconsciousness. The mother may be taught that but not the child.

8. *Health hygiene*: During the daily bath teach her health hygiene so important with this illness: to keep her body clean and well dried, hair well groomed, teeth cleansed after each meal; to keep her toe-nails cut straight across; to attend to any small cuts, pimples or boils; to obtain ten hours sleep every night in a well-ventilated room; to report to her mother if she is not feeling well so her mother may in turn consult the doctor.

9. *Elimination*: There should be at least one bowel movement a day. If a laxative is sometimes necessary it must be mineral oil or liquid paraffin because these contain no sugar.

The points I have stressed must be taught slowly, over a period of time. The child's questions will be your guide. She must not be overwhelmed with information, but absorb each point fully. You must have great patience with her and encourage her from day to day. Many mistakes will be made and these you must discuss together. Always be fair in your dealing with her. If she is able to absorb this teaching and assume responsibility for herself her future well being is assured.

The week prior to Mary's discharge from hospital her mother will come to the hospital daily to receive complete instruction for her future care. Mary will attend many of the conferences with her mother and if by that time she fully understands about her disease and its treatment it will greatly ease the strain and tension for her mother.

Obituaries

Amy Des Brisay died recently in Montreal. Miss Des Brisay was a graduate of the School of Nursing of the Montreal General Hospital and a member of the Class of 1908. She was a most capable and conscientious private duty nurse and will be held in grateful remembrance by her patients. Miss Des Brisay was a charter member of her Alumnae Association.

Mrs. Melvin Hickey (Dorothy E. Mitton), of Alma, N.B., died recently at the Moncton Hospital. Mrs. Hickey was a graduate of the School of Nursing of the Saint John General Hospital and a member of the Class of 1938. Her many friends are deeply grieved by her death.

Ethel McNamee died recently in Vancouver, B.C. She was a graduate of the School of Nursing of the Kingston General Hospital and served overseas during the first Great War with No. 7 Canadian General Hospital. Her subsequent career was devoted entirely to military nursing service in Kingston, Ste. Anne de Bellevue, and the Shaughnessy Military Hospital in Vancouver.

Miriam Mercer, director of the health service in the School of Nursing of the Montreal General Hospital, died recently. Miss Mercer was a graduate of this School and a member of the Class of 1926. After taking a post-graduate course in public health nursing at the McGill School for Graduate Nurses, she served for several years as a member of the nursing staff of the Victorian Order of Nurses.

Mrs. J. B. O'Neill (better known as Sister Simpson) died recently in British Columbia. She was a graduate of the School of Nursing of the Winnipeg General Hospital and a member of the Class of 1893. For thirty-five years she rendered devoted service as a private duty nurse and, in spite of her advanced years, retained a keen and active interest in nursing affairs.

Annie Smith died recently in Ottawa, Ontario. Miss Smith was a graduate of the School of Nursing of the Montreal General Hospital and a member of the Class of 1896. For many years Miss Smith practised her profession with great success—first in Montreal and later in California.

Notes From the National Office

Contributed by JEAN S. WILSON,
Executive Secretary, The Canadian Nurses Association

Provincial Associations

Since the General Meeting in 1942, of the Canadian Nurses Association, the programme of the Provincial Associations of Registered Nurses has been largely concerned with putting into effect the recommendations which arose from the first report on findings by the Emergency Nursing Adviser to the Association. The development of these activities is recorded in the report of the Emergency Nursing Adviser which appears in each issue of the *Journal*, consequently they are omitted in the following summary of reports by the provincial associations to the Executive Committee.

Under the auspices of the *Alberta Association of Registered Nurses*, the School of Nursing of the University of Alberta is to offer a summer school course in public health nursing and in teaching and supervision. Credits obtained can be applied toward a degree course. A qualified public health instructor is to conduct a public health teaching programme, which will include principles and methods of teaching in health education, to second year students; and community health to third year students in schools of nursing. A year's subscription to *The Canadian Nurse* was given by the Alberta Association of Registered Nurses to each of fifteen candidates who obtained honour standing in the recent examinations for registration.

The *Registered Nurses Association of British Columbia* has organized two more complete districts. An acute shortage of general staff nurses for hospitals continues to exist although many private duty nurses have offered to serve a month on general staff duty in their local hospitals. The revised plan under consideration for a placement service is that one central office would provide such a service on a provincial basis and through which regional branches would be established and guided where and when needed.

The *New Brunswick Association of Registered Nurses* held a most successful institute for young staff nurses when arrangements were made for the attendance of two staff nurses from each school of nursing in the province. A travelling instructor has been appointed to carry on in-service education and to give additional lectures where necessary. Schools of nursing have been discontinued by the J. H. Dunn Hospital at Bathurst, and by the Hotel Dieu at St. Basil.

The *Registered Nurses Association of Nova Scotia* has, for a period of six months, waived payment of fees in arrears of nurses who once were registered in the province and who thus are permitted to secure membership upon payment of the current fee only. Temporary registration permits are being issued to nurses who, at the time and place of graduation, were eligible for registration upon payment of the provincial registration fee; annual renewal of this permit will be allowed for the duration. Quite a number of nurses have taken advantage of these provisions. All candidates (98) successfully

passed the recent examination for registration of nurses.

All chapters within the district organizations of the *Registered Nurses Association of Ontario* report continued interest and activity. At the request of District 5 and the Central Registry of Toronto, a series of lectures—"Some Aspects of Nursing Care in War Time" were arranged by the University of Toronto School of Nursing. The R.N.A.O. Annual Meeting is to be held on April 28-30, 1943, in the Royal York Hotel, Toronto.

The *Registered Nurses Association of Prince Edward Island* arranged for the attendance of several members at the institute for young staff nurses recently held in Saint John, N. B. An eight-hour schedule with increased fees has been adopted for graduate nurses of Charlottetown, while those in Summerside continue twelve-hour duty with increase in fees.

The annual meeting of the *Association of Registered Nurses of the Province of Quebec* will be held in the Windsor Hotel (English Section) and in the Plateau Auditorium (French Section) on May 17 and 18, 1943. Amendments to the Act of Registration for Nurses in the Province of Quebec are now before the provincial legislature. A number of married nurses have secured registration, some of whom are engaged in strenuous rural nursing mostly on a voluntary basis.

The *Saskatchewan Registered Nurses Association* sent a questionnaire to all hospitals in the province in an endeavour to learn if refresher courses in their districts were desired. An attractive display entitled "Opportunities in the Nursing Field" has been widely shown in the recruiting of student nurses campaign. Four local associations of registered nurses have applied for organization as chapters of districts of the S.R.N.A.

Loans

Since September 1941, seventeen nurses have secured loans from the Canadian Nurses Association to a total amount of $4,952. These loans are offered for post-graduate study and experience which is taken in Canada, except when the type of course desired cannot be obtained in this country; decision for the granting of a loan for study elsewhere is determined by the loans committee. The maximum amount of a loan is five hundred dollars and repayment is to commence during the year following the completion of the course; security required is by posting a bond or by one or two guarantors; in the event that the recipient leaves the nursing profession for marriage, or any other reason, before payment is completed, the total balance still owing is to be repaid at once. Loans are interest free for three years from date of issue. The Canadian Nurses Association offers loans not only for the benefit of its members but also for the benefit of nursing service in Canada; therefore any nurse who secures a loan is asked to agree to serve in Canada for at least two years and until the loan is refunded. Requests for application forms should be sent to the Executive Secretary, Canadian Nurses Association, 401-1411 Crescent Street, Montreal, P. Q.

Membership

The total membership of the Canadian Nurses Association is now 19,137, as compared with 18,266 in 1942 and with 9,501 in 1933; or an increase of over fifty-one percent in the past ten years. According to provinces the present membership is: Alberta, 1600; British Columbia, 2860; Manitoba, 1686; New Brunswick, 754; Nova Scotia, 1166; Ontario, 5356; Prince Edward Island, 109; Quebec, 4370; Saskatchewan, 1236.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Have we Kept our Pledge?

GLADYS E. BROWN

Medicine and surgery have gone ahead rapidly, especially since the first World War. Already we are hearing about new drugs, new theories, better operating technique. Nurses must keep up with this progress. These are days of keen competition in the business world and this is true (or very soon will be) in the field of nursing. In some parts of Canada there is a shortage of trained nurses and, to meet this shortage, young women are being trained as nurses aides or practical nurses. I have worked with some of these young women and was amazed at their nursing skill. Many are seizing this opportunity to learn as much as they can about the care of the sick. It is true that their training is a meagre one, but many of them have had experience raising families or caring for relatives at home. Experience is important to any nurse. Is it not a reasonable assumption that these women may, to some extent at least, take the place of graduate nurses? Their wages are less than that of graduates and their training is making them capable of looking after many types of cases. These women are doing good work and are essential to the war effort, but is it not time for us to think of our professional standards?

Not many years ago, a trained nurse was regarded as one who carried trays, bathed patients, made beds, fed the babies, did the dusting and any other odd job at hand. Progressive leaders in the nursing profession today think differently. Nursing is a profession which requires three years of special preparation and, at the end of that time, one finds her training has just begun. The nurse then enters the "school of experience" from which no one ever graduates.

After graduation, the young nurse soon learns that she has entered a new sphere in life. Her training has given her a splendid foundation on which to build, but to be a successful nurse she must continue to build. In this process, character plays an important part. Character means respect for and loyalty to one's inner self, a passion to keep it inviolate; it means unfailing consideration for the rights and needs of one's fellow men. It means the courage to fight the battles and make the sacrifices which are inevitable in preserving the integrity of one's soul and practising sound and unfailing consideration for others. Character is true wealth, and any girl, anywhere, may develop that kind of wealth.

Have you not heard a group of people discussing nurses? I have always found

the conversation very interesting and profitable, especially if it was not known that I was a nurse. From such a conversation I learned that most people have a great respect for our profession but they are nevertheless quite critical.

It would seem to be almost impossible to live up to all that is expected of us, but we must keep the standard high. Such pioneers as Florence Nightingale, Jeanne Mance, Edith Cavell began this wor. We must carry it on. Do we realize that the future of nursing rests in our hands? We are pledged: "to do all in our power to elevate the standard of our profession." Have we kept our pledge? Ours is a wonderful heritage. The noble women, whom we succeed, have handed us the torch saying, "Be yours to hold it high".

Annual Meeting of the A.R.N.P.Q.

The annual meeting of the A.R.N.P.Q. will be held on May 17 and 18, headquarters for the meeting being the Windsor Hotel, Montreal. The opening afternoon session will be devoted to the president's address, reception of reports, nomination of scrutineers, and the reception of the nomination ticket. The president will preside and the meeting will be bi-lingual. At 8.30 p.m. there will be two sessions, conducted separately in English and French, but running concurrently. At the English meeting, Mr. C. R. Armstrong of the Bell Telephone Company will speak on "What industry expects from its health service". Miss Ethel Johns has chosen "Towards a New Horizon" as her topic. At the time of writing, speakers for the French session that evening have not all been secured but it is planned to devote the entire session to industrial nursing; the Rev. Fr. Emile Bouvier, professor in the School of Social Service, University of Montreal, will present the social service point of view. Mlle Maria Beaumier will preside.

A session will be held at Hôpital Notre-Dame on the morning of May 18 when the Rev. Soeur Décary, Director of Nursing, Hôpital Notre-Dame and Chairman, Hospital and School of Nursing Section (French group) will preside. The program will include an address by Dr. Georges Hebert on "The importance of a well organized health service in a school of nursing". The teaching of hygiene at the bedside of the patient by the student nurse will be discussed by Mlle Alice Girard, directrice, Ecole d'Infirmières Hygiénistes, Université de Montréal. At 2.30 p.m. sessions, conducted separately in English and French but running concurrently, will deal with a symposium on health insurance and nursing service. Miss Fanny Munroe, chairman of the A.R.N.P.Q. committee on health insurance and nursing service (English group), will conduct the symposium in English. Mlle Maria Roy, chairman of the A.R.N.P.Q. committee on health insurance and nursing service (French group), will conduct the symposium in French.

At the afternoon meeting on May 18, Mlle Juliette Trudel will address the French-speaking nurses on "La guerre et nous". Mlle Trudel is provincial emergency nursing adviser for the French group of the A. R. N. P. Q.

The evening sessions will be held separately, the English group in the Windsor Hotel and the French group in Plateau Auditorium, so that Religious Sisters may be able to attend. At the English meeting, Dr. Herman Finer of the International Labour Bureau will speak on "Social Problems in the Post-War World". Miss Beryl Truax, vice-president, Canadian Teachers' Association, will speak on "The Role of Women in a Democracy". Another speaker from the International Labour Office will address the French members on the same subject as that chosen by Dr. Finer and their program will conclude with an address on "Les Indiens avant la découverte de l'Amérique", by Dr. Philippe Panneton. A large attendance is anticipated, for the weather is sure to be fine and no one can dispute that the program is a good one.

E. FRANCES UPTON
Executive Secretary and Registrar

Seven Days Adrift in a Lifeboat

BARBARA MITCHELL-HEGGS

We were getting very near land when our ship was bombed by an aeroplane which came suddenly upon us out of the low clouds. The bomb got the engine room and caused the ship to list very slightly but we had no further hit. As it was breakfast-time most people were in the dining-room. We were told to take cover from the stairways and heard a lot of noises suggestive of bombs missing their target and dropping into the water. Machine-guns rattled, our gallant little volunteer gun crew doing their part most nobly. As the plane went off, there was a call for a doctor. Being a nurse, I nipped along, too, to the little surgery where the Lady Doctor and I dealt with a Chinese stoker who had a bullet in his thigh. The ship's doctor had gone down engine-room way where two men had been killed outright. We heard the plane come back, more noises, and then away it went. Next we had the order to abandon ship and to line up at boat stations. As it was winter and cold, stewards shouted to people to grab blankets from the bunks of the cabins not smashed up. For some reason our deck station was unsuitable, so we went to another and after all boats had been lowered in great haste we slipped down the rope ladder into our life-boats. We were a very empty ship as regards passengers and so there was no lack of space. All the same, the 22 in our boat seemed more than enough.

The boat I was in waited by the ship's side until all other boats had gone because we should have carried the captain. However, he decided to stay aboard together with the engineers and other skilled seamen. We found out afterwards that the wireless had been hit and they wanted to get the emergency one going. They did get an S.O.S. out and a gun-boat eventually collected the other boats.

We all helped to manipulate the big oars and moved away from the ship. Unfortunately, with the currents, we could not join the other life-boats and very shortly the sea which had been moderate, became increasingly alarming. Rain poured down and the east wind seemed to cut us like knives. Soon the seas were really tremendous and great big rollers like rows of houses bore down on us. Yet, by some miracle it seemed, as long as we rowed and backrowed and kept the little boat headed straight, we were lifted up. But sometimes in the long night we were not quite quick enough and a ton of water descended on us, soaked us through and through and partly filled the boat. However, our bodies acted as a kind of lid and kept much of it out. As it was, we threw the water out with everything available. How that little boat survived I don't know. We sat with water up to our waists. We just couldn't keep it down. Flares were sent up until even the special matches were soaked. Also, the oil was used to keep the sea from coming in so freely.

That storm lasted until the end of the second day and by night we just lay exhausted. The next morning the two who were already dead were put overboard. Others were passing into a drowsy stage, followed quickly by coma and they, too, died. As a nurse, I never felt so helpless in my life. We couldn't even let them lie down comfortably; we tried to keep them out of the water and wrapped our wet blankets around them. The brandy was a great help and all needed it; yet all too soon they could not swallow. By the end of the third day I think eight had died.

The weather had become more manageable and we hoisted the sails. The first time we ran them up the jib-sail half blew away and the ropes tying the big sail to the mast broke in several places and we almost lost the sail. We gradually got the water baled out and tried to make things more comfortable. With the nails out of the packing-case which held the corned beef tins and with bits of wood from the same source the tarpaulin was secured to one side of the boat. This meant that at night we drew it across and it sheltered us from the extreme cold and also helped to prevent us shipping so much water. Each man took his turn at the tiller — a freezing job. Earlier than this we had discovered that one water barrel had the bung right out and that the water was hopelessly contaminated. The other barrel had been near where the Chinese sat huddled together and they had drunk pretty lavishly; so the barrel and one dipper (the others had got lost overboard) were put in charge of our "Captain" O'Brien, the one A.B. in our boat. He consulted with me and it was decided that the water should be issued early morning and evening and one tin of sweetened condensed milk shared round at midday. Corned beef and ships biscuits were available for all who could masticate them. The brandy I issued the very first thing early morning and when it was finished I made up a mixture of sal volatile from the little bottle in the first-aid tin and issued that.

The night seemed interminable and as no one could lie in comfort, it was impossible to do more than doze. We waited anxiously for the light to be sufficient and then every one watched the sharing out of the water. Two-thirds of a dipperful were put into empty condensed milk tins so that we could sip the water more slowly. The condensed milk made us thirsty, and towards the end, with our swollen tongues and parched throats we found biscuits and corned beef impossible and condensed milk tantalizing. Though no more died, each day another one dropped out of the working members as it were. On the one day that it was fine for a while, we tried to wring out the wet blankets and hung them about to dry, but evening came all too soon and with it a little squall, and we were soon just as wet as ever. The rain was very welcome for drinking but it took such a time to wash the brine off the sails first. Several times it rained hailstones and we gathered these up and ate them—they made all the difference.

By daylight the steering was easy but at night when we could not see the compass and no moon was shining, we most of us had a feeling we were going round in circles. Needless to say, we pretended we had steered a straight course. On the evening before we were picked up I had begun to sip the salt water. It glittered so tantalizingly and all the time one thought of nothing but water. Sometimes I would see cups of tea ready to drink in front of me, mugs of beer and glasses of lemonade. The men, too, suffered in the same way. The seventh morning was a clear and calm day. When we rolled back the tarpaulin and doled out the water, two of the best and bravest were quite mental and had to be held to prevent them trying to walk off the ship. Luckily they were very weak. None of us could stand and we fell over each other and dragged ourselves to the tiller. The chapping caused by our wet clothes did not help. We were discussing whether we should reduce the water supply still more and rely on a kindly shower, in the hope that land would show up, when in the sunlight we saw a little aeroplane silhouetted against the white clouds. It came nearer and nearer and soon we could see the British markings and next it was dipping low down round our boat. We all waved and waved and felt lots better. It circled and dipped a few times and waved back and then it disappeared,

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soon to return with another plane and both circled round us. Then we saw in the distance the lovely vision of a destroyer cutting through the water like a knife with the spray as high again as the stern. With the aid of calm weather and good organization they came alongside our boat and young sailors tumbled in offering cigarettes. Eventually with the aid of ropes and naval stretcher, all were aboard. As a matter of fact, after I had told the doctor about the need for stretchers for most, he asked how I could manage and I was lifted into a sort of rope chair and hauled up. They insisted on taking me up first and I can remember the grey iron decks and going down step stairs and the lovely dry look of the Captain's cabin in soft blue and grey. I remember I was a little surprised not to feel the blankets warm but of course, it was because all my skin was a little insensitive. The kind-hearted sailors asked what I'd like and I asked for a drink. Three cups of broth just vanished and I can remember being artful and each time anyone fresh came along I asked for a drink until the doctor arrived. He and a married steward undressed me and a big drink of rum followed. As a result I was soon sound asleep and only woke when one leg began to hurt me. The pain was pretty grim and I remember the inadequacy of the morphia. It made the pain recede but never stopped it and then all too soon the waves of pain began to increase again.

The one thing that helped so much was the constant stream of visitors from the ship's company who tried to distract me by showing me pictures of their sweethearts, and telling about their homes in the different parts of Canada. I just felt I had to live up to their idea of me. What a lot of quiet laughter I got while being "nursed" by the surgeon and steward. The bottom sheet stayed 'put' the whole six days. To lift a blanket made me feel quite tired, and to add to my two useless legs, I'd an enormous boil on one hip and a stiff neck from infection of a parotid gland. Nor was my narrow bed stationary; on the contrary the ship curved and twisted all the time.

This dear Canadian destroyer produced a lip-stick and powder for me, lavender water and even cold cream. The married steward, my personal attendant as it were, gradually got my hair untangled. The black bit came off my nose together with layers and layers of skin. My fingers still stayed rather useless at the finger tips.

Well, one day we were all landed where a loyal little town couldn't do enough for us all. The only other woman in the boat died about the third day.

Editor's Note: This vivid story is quoted from the December 1942 issue of the Journal published by The Nightingale Fellowship of St. Thomas's Hospital. The true spirit of nursing shines in every line of it. The Lady of the Lamp may well be proud of her inheritors.

Pratical Hints from a Married Nurse

I've heard of several young nurses who get "stuck" when they are out in the country because they are used to running to a drugstore for every little thing they need.

There were no rubber nipples to be had up here not long ago, so a dear old granny made one out of cloth as she used to do and gave it to a modern young lady's baby. It worked too! Young nurses seem to forget that people used to get on without rubber hot water bottles. An iron wrapped in newspaper and then in a woollen cloth will keep hot all right. Be sure it is not too hot.

——R. DOROTHY J. HATHERLEY

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STUDENT NURSES PAGE

A Mastectomy

GRACE CARTY

Student Nurse

School of Nursing, Cornwall General Hospital

Mrs. A. was admitted to the Cornwall General Hospital with a diagnosis of carcinoma of the breast. The pathological report following surgery defined it as scirrhous carcinoma, that is a cancer with a predominance of connective tissue. Mrs. A. is thirty-five years of age, the oldest of a family of three. She is the mother of two children, aged two and four years. She breast-fed both children and there was some "caking" in the breast during lactation. The lump was noted accidentally while taking a bath and, being alarmed, she went to see her doctor who advised a breast amputation. On admission, a thorough physical examination was done, including chest x-ray, blood examination and urinalysis. No pathology was found, other than this painless, oval hard lump on the upper outer quadrant of the left breast and, fortunately for the patient, not adherent to the underlying structures.

Carcinoma of the breast begins with a painless hard lump which without treatment increases in size, invades the surrounding tissues and extends to the lymph glands in the adjacent axillae, causing enlargement of the axillary lymph glands. This mass becomes attached to the deeper muscular layer of skin producing a characteristic orange peel appearance of the skin and inverted nipple. If the condition has lasted for some time, the patient may be emaciated, pale, anemic and weak. Death may follow in two or three years.

Pre-operative preparation consisted of preparation of the skin from beneath the jaw to the umbilicus and well beyond the midline in front to the midline in the back of the affected side. A soapsuds enema was given the evening before operation, and a sedative to ensure a good night's rest. On the morning of operation nembutal grs. 3 with morphine gr. 1/6 and atropine gr. 1/150 were administered one half-hour before operation. Atropine is given to lessen secretion, while nembutal and morphine allay fear and nervousness and shorten the induction period of anaesthesia.

Surgery consisted of a radical mastectomy. By radical is meant an operative procedure intended to effect a complete cure by excision of the entire breast and the underlying muscle down to the chest wall, with the nodules and lymphatics which drain it in the axilla, in order to insure complete removal of all tissue which might contain cancer cells.

On return from the operating room Mrs. A. was given a pint of normal saline rectally by catheter every four

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hours for three doses, an intravenous of 2000 c. c. of glucose saline 5%, fluids by mouth when nausea ceased, with soft diet the following morning. Fluids are important because they make up for the loss of blood during operation and help to prevent shock. The patient was put in semi-Fowler's position when conscious to aid in drainage and because it is the most comfortable position. Morphine gr. 1/6 was given when necessary for the first twenty-four hours to lessen pain. Frequent inspections of the dressing were made to watch for any symptoms of hemorrhage and reinforcement of the dressing was done when necessary. The arm on the affected side was kept close to the side during the first 48 hours to prevent strain as the skin is closed under considerable tension. On the fourth day, passive exercise was begun and gradually increased till the patient was able to use the arm without difficulty. This is necessary to prevent adhesions during healing which may cause limitation of arm movement.

Mrs. A. complained a few times of having a feeling of smothering and tightness in the cardiac region and a slight dyspnea was noticed at these times. This was probably due to the large number of clips and sutures and to the extensive loss of tissue. On the second post-operative day a few clips were removed and this relieved her. On the fifth day, the remaining clips and the drain were removed; a large amount of serosanguineous discharge was liberated from the stab wound in the axilla. The sutures were removed gradually as healing progressed. Cod liver oil ointment and metaphen were applied to the incision to prevent infection and promote healing. An enema was given on the second post-operative day and the patient then given a light diet; after this the bowels were regulated by the use of a laxative.

Mrs. A. was allowed out of bed at the end of the first week and discharged three days later. About seven weeks after her operation a series of x-ray treatments was begun in order to kill any cancer cells that may have escaped. She is now in good health with excellent use of her arm and no symptoms of any further carcinoma. From this case study I learned the importance of early recognition and treatment of carcinoma, the nursing care of mastectomy and treatment to prevent complications, and the value of x-ray therapy following surgery.

Annual Meeting of the M.A.R.N.

The annual meeting of the Manitoba Association of Registered Nurses will take place in Winnipeg at the Royal Alexandra Hotel on Friday, April 16, and Saturday, April 17. The first morning will be devoted to a business session and will be followed by a luncheon sponsored by the Public Health Section. In the afternoon, the presidential address will be delivered by Mrs. A. C. McFetridge and the report of the School of Nursing Adviser will be given by Miss Gertrude Hall. The evening session will take the form of a Jury Panel on the future of nursing and the list of participants assures a lively and challenging discussion. On the following morning considerable time will be devoted to *The Canadian Nurse* and an address will be given by the editor. At the afternoon session, a group of speakers will discuss the medical and nursing care of burns. A banquet has been planned for the evening at which Miss Ethel Johns will speak and a novel and stimulating item will be contributed by the Poetry Society.

GERTRUDE M. HALL
Executive Secretary

NEWS NOTES

ALBERTA

EDMONTON:

A regular monthly meeting of the Royal Alexandra Hospital Alumnae Association was recently held. Plans for a St. Patrick's dance were completed, and Red Cross dressings were made.

BRITISH COLUMBIA

The Vancouver Chapter of the Greater Vancouver District of the R.N.A.B.C. recently held its first annual meeting. Progress has at times been slow but the R.N.A.B.C. has come to our rescue, not only with timely advice, but with a well-planned outline for the guidance of each section. Our objective is to stimulate public interest in nursing and to stimulate the interest of nurses in community affairs. Our three projects—two refresher courses and the emergency enrolment—have been completed and from our refresher courses we now have 200 potential associate members.

VERNON:

The annual meeting of the Vernon Chapter, R.N.A.B.C. was held recently with 20 members present. The officers elected for the coming year were: president, E. H. Picken; vice-president, Mrs. W. T. Mathers; secretary, L. Purvis; treasurer, Mrs. F. F. Becker; entertainment committee: A. Langstaff, M. Mills, Mrs. H .W. N. Moorehouse, Mrs. G. Schuster, Mrs. Allan O. Davidson; phone committee: Mrs. Moorehouse, Mrs. Schuster, Mrs. Davidson; publicity: Mrs. W .S. Harris, Mrs. J. Markle.

Under the auspices of the Chapter, Miss Dorothy Mickleborough, field supervisor of the Victorian Order of Nurses for Canada, recently delivered a very interesting address which gave a clear picture of the activities of the Order and of the opportunities which it offers to registered nurses in Canada. Miss Mickleborough is well known in Vernon where at one time she was a member of the staff of the Vernon Hospital.

KAMLOOPS:

Royal Inland Hospital:

The following are taking post-graduate courses: Miriam Warren and Joan Campling, in surgery at St. Michael's Hospital, Toronto; Norma Brydon, in surgery at the Vancouver General Hospital; Caroline Farina, in public health at the University of British Columbia. The following have recently accepted positions: V. Mason, I. Hymers, and D. Downey, at the Nanaimo General Hospital; N. Mauld and E. Slack, at Port Alberni General Hospital; M. Aikman, at Hazelton Hospital; Peggy Finch, as stewardess with the Trans-Canada Air Lines.

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Wharton, Jr., J. B.: Tri-Sta. Med. Jl., p. 2252, April, 1939.

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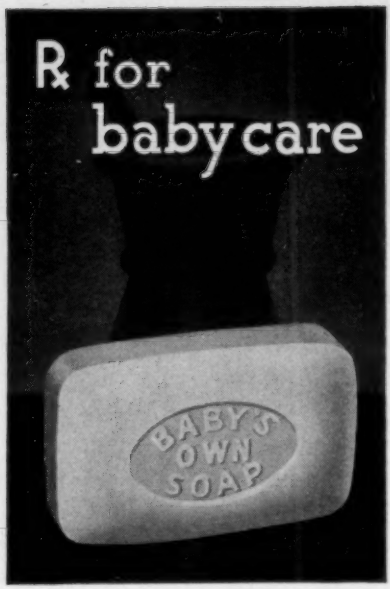

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PRODUCTS

The Kamloops-Tranquille Chapter, R. N. A.B.C. recently held a successful tea, the proceeds going to war charities.

MANITOBA

BRANDON:

At a recent meeting of the Brandon Graduate Nurses Association the vice-president, Mrs. H. Alexander, presided and the Private Duty Section were in charge of the meeting. Miss G. Lamont, introduced Mrs. A. E. Burn who reported the findings of the committee for the licensing of all those who nurse the sick for hire based on reports from Ontario, New York, and the Nursing Reconstruction Committee in Great Britain. Reports from the General Hospital Group, the Married Ladies Group and Mrs. S. J. Pierce, convener of the war work committee, showed that money and many useful articles had been donated to various good causes. Mrs. D. L. Johnson announced 63 paid-up members. Mrs. A. E. Burn, on behalf of the Scholarship Committee, reported keen interest by those contacted.

NEW BRUNSWICK

SAINT JOHN:

At a recent meeting of the Alumnae Association of the Saint John General Hospital Agnes D. Carson was presented with a school pin in appreciation of her 50 years of active service. Miss Carson entered training on November 17, 1892, and was the first district nurse in Saint John. She is still on active service and is on duty at the Saint John Tuberculosis Hospital. At the same meeting Ada Burns was presented with a silver compact on behalf of the Alumnae Association. Miss Burns is resigning after 14 years service as supervisor of the local branch of the Victorian Order of Nurses. Florence Greenway succeeds Miss Burns.

NOVA SCOTIA

KENTVILLE:

At an executive meeting of the Valley Branch, R.N.A.N.S. held recently at the home of Mrs. P. Webster, the president, plans were made for a telephone bridge, the proceeds to go toward the provision of a home for ageing nurses.

Madeline Millard and Ann Brinton have resigned their positions as staff nurses at the B.F.M. Hospital.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

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District 1

The election of Mrs. Constance I. Salmon as Chairman of District 1, R.N.A.O. has been a source of satisfaction to the authorities of the Chatham Malleable & Steel Products Company. In hercapacity as industrial nurse she has been active in many phases of the Company's welfare work and has been invaluable in reducing absenteeism due to illness.

Chatham:

The industrial nurses of Kent County recently organized into the Kent County Chapter of Industrial Nurses, with Jean Rickard of the Ontario Steel Products as chairman, Mrs. C. I. Salmon of the Chatham Malleable & Steel Products as vice-chairman, Hilda Melanson of Libby, McNeill & Libby as secretary-treasurer. The program committee consists of Mrs. Agnes O'Flynn of the Dominion Glass, Wallaceburg, and Luella Smythe, Chrysler Corporation, Chatham. A letter of congratulation and greetings was received from Mildred Walker, president of the R.N.A.O. Valuable information was exchanged during the round table discussion.

Windsor:

Grace Hospital:

Windsor's population has increased 43,000 since the beginning of the war so the hospitals are naturally taxed to capacity. However everything is being done to meet the needs of the patients and increase the educational content of the students' training. A clinical instructor and 6 extra supervisors have been added to the nursing staff.

A refresher course is being conducted by Major Doris Barr, superintendent of nurses, for graduate nurses who have not been actively engaged in nursing. Thirty-one have enrolled and, following the lectures, come to the hospital for 4 hours daily for practical experience. Classes are also being given for the Civilian Defence Corps. The ward aides have 20 hours of lectures and demonstrations and then come to the hospital for 60 hours practical experience. Male orderlies are being trained for the local Navy barracks and first aid departments of the large war factories.

The formula room provided by the Alumnae Association is meeting a great need and the tea room provided by the student nurses is also very useful for visitors who do not wish to leave their relatives when they are seriously ill.

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(3) A course in operating room technique and management is offered to nurses with graduate experience in operating room work. (4) Courses are also offered in medical nursing; surgical nursing; nursing in diseases of the eye, ear, nose and throat; nursing in urology. For further information apply to Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital.

District 4

HAMILTON:

St. Joseph's Hospital:

Identification bracelets were presented by St. Joseph's Hospital Alumnae Association to Nursing Sisters Elizabeth Cocker and Ivy Hart, R.C.A.M.C., prior to their leaving for overseas duty.

District 5

At the annual meeting of District 5, it was reported that 900 nurses are attending the refresher course given jointly under the Central Registry and District 5 and directed by the University School of Nursing. Mary Hughes, speaking for the general nursing section, said nurses had been exceptionally busy and that it had been difficult to meet all calls. Married and retired nurses are helping to meet the shortage in the voluntary field after completion of refresher courses. The Central Registry has been reorganized. Reporting for the hospital and school of nursing section, Blanche McPhedran said their activities have centred around problems arising in their own group. Lillian Pettigrew announced the organization of industrial nurses as a subsection of District 5, public health section. Gwladwen Jones reported on courses carried on during the year, offering emergency nursing lectures and practice periods. Jean Mitchell announced that nearly 3,000 nurses have enrolled as a result of the recent Emergency Nursing Registration campaign.

Officers elected were: chairman, Kathleen McNamara; vice-chairmen, Pearl Morrison, Lillian Pettigrew; secretary-treasurer, Mrs. G. L. Williamson; section conveners: general nursing, Mary Hughes; public health, Louise Tucker; hospital and school of nursing, Blanche McPhedran; councillors: Olive Brown, Edith Hill, Ella Grant, Gwladwen Jones, Muriel Winter, and Roselle Grogan.

District 6

At the annual meeting of District 6, held in Cobourg, the afternoon meeting was given over to the discussion of business and the election of officers for the coming year took place. A dinner meeting was held at which 36 members were present. Edna Moore, chief public health nurse for Ontario, was the guest speaker, her subject being "Nursing in 1942". She spoke of the various nursing organizations and the assistance their members had offered to the Federal Government in the present emergency, and urged increased membership in the organization and loyal support by nurses in all their undertakings. Captain L. M. Goddard, a retired sea captain, took his

audience on an enjoyable imaginary sea voyage to many lands. Miss J. Graham and the nursing staff of the Cobourg Hospital entertained the members at a social hour.

Belleville General Hospital:

At a recent monthly meeting of the Belleville General Hospital Alumnae Association reports were given by the different conveners, and the following officers were elected for the year 1943: president, Mrs. A. E. Miles; first vice-president, N. Bush; second vice-president, M. Peacock; secretary, Grace Donnelly; treasurer, K. Brickman; registrar, D. McColl; committee conveners: program, M. Miles; social, Nina DiCola; flower and gift, M. Bonter; Dr. Connor's Memorial Ward, B. Soutar; representative to press and *The Canadian Nurse*, Mrs. M. Plumton.

District 7

The following is a list of the officers of District 7 for the year 1943: chairman, Ella G. Smith, Ontario Hospital, Kingston; first vice-chairman, Helen Corbett, General Hospital, Brockville; second vice-chairman, Doris Storms, Public Health Department, Kingston; secretary-treasurer, Pearl Gavan, Ontario Hospital, Kingston; councillors: Evelyn Freeman, Kingston; Bertha Griffin, Perth; Mary E. Hanna, Smiths Falls; Edith Moffatt, Brockville; Pearl Gavan, Kingston; Sr. St. Donovan, Kingston; hospital and school of nursing section: convener, Louise Acton, Kingston General Hospital; Sr. St. Oswald, Ella Smith, Elizabeth Waldron; general nursing section: convener, Helena Bell, Kingston General Hospital; Amy Church, Kathleen Walsh, Bertha Griffin; public health section: convener, Beulah Fry, school nurse, 59 West, Kingston; Isobel Black, H. Smith, Frances Docker; membership committee: convener, Mrs. Dorothy Ferguson, Ontario Hospital Kingston; R. B. Sheffield, Bertha Griffin, Eleanor Crosby, Sr. St. Oswald; finance, Helen Corbett, Brockville General Hospital; convener for contingency fund, Helen Corbett; program committee: convener, R. B. Sheffield, Ontario Hospital, Brockville; Jean Guest, Sr. Mary Immaculate, Mrs. Nelson Silver; publications, Jean Carty, Ontario Hospital, Kingston; *The Canadian Nurse*, B. Coulter, Kingston General Hospital.

Kingston General Hospital:

A recent meeting of the Alumnae Association of the Kingston General Hospital took the form of a pot luck supper. Mrs. D. J. Cunningham outlined the work of the emergency reserve which is being organized

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in conjunction with the civilian defence committee. The services of 100 graduate nurses are urgently needed. It is a purely voluntary movement made up of women who will tend sick or wounded in their own communities if an epidemic or disaster should strike. Each group is to be headed by a graduate nurse. Nurses are asked to register immediately at the department of health in the City Buildings.

DISTRICT 10

A meeting of District 10 was held recently in St. Joseph's General Hospital, Port Arthur, with 57 present. Nursing Sister Norstein, who has been invalided home, gave a very stimulating talk on her experiences in England. Miss McKinnon, superintendent of the Port Arthur General Hospital, read an interesting letter from her former assistant, Miss Hunter, who is now located in a hospital in Scotland. Miss M. Bliss, chairman of the public health section, reported that special attention is being paid to organizing industrial nurses as a division of this section. Miss I. Misener, chairman of the hospital and school of nursing section, reported that a monthly meeting will be held and that all supervisors, assistant supervisors, and staff nurses are invited to participate in the study groups and round table discussions. A social hour was then enjoyed.

A very pleasant dinner meeting was held recently in Port Arthur by the public health section of District 10. Among those present were public health nurses from Fort William and Port Arthur, the Metropolitan Life visiting nurse, the superintendent of nurses at the Fort William Sanatorium, five school nurses from both cities, and four industrial nurses. A monthly meeting is to be held and a short paper will be given at each meeting on some subject of general interest. Each member will share in the discussion and will take turn synopsizing the articles in *The Canadian Nurse* and the Public Health Nursing Journal for the current month. For organization purposes Miss Hubman will look after Fort William nurses, Mrs. Jarratt, the industrial nurses, and Miss Bliss, the Port Arthur nurses.

QUEBEC

MONTREAL:

Montreal General Hospital:

The staffs of the Central and Western Divisions recently held a concert in aid of the mobile canteen fund, sponsored by the graduate nurses.

Clara Jackson has resigned her position as instructor of nurses at the Brantford General Hospital and is now travelling instructor for the Province of Saskatchewan.

Kathleen Derby has resigned from the staff of the Central Division and has been appointed to the Nursing Service of the Royal Canadian Navy. Margaret Harrison replaces her. Kathleen Hayward has also been appointed to the Royal Canadian Navy Nursing Service. Thirza McCullough has been appointed to the R.C.A.M.C. Nursing Service. Mrs. Danforth (Jean Picken) has resigned from her position on the night staff. Helen Thompson has been appointed to fill the vacancy. Daphne Moore has accepted a position as industrial nurse.

Royal Victoria Hospital:

Misses Keilson, Mansfield, Hewson, T. Murray, M. MacKenzie, Devlin, and Mrs. Grovena Ireland are on the staff of the Royal Edward Laurentian Sanatorium, Ste. Agathe des Monts. Margaret MacMillan is doing general duty at Verdun Protestant Hospital. Margaret Heeney has been appointed superintendent of Trail-Tadanac Hospital, Trail, B. C. Isabel Lewis, head nurse on 2nd floor, Ross Pavilion, has resigned and has been succeeded by Alice Crickard. Clara Cook is assistant head nurse on 2nd floor, Ross Pavilion, and Elizabeth Millar on 5th floor, Ross Pavilion. Florence Gass is in charge of Ward A, Men's Medical. Misses Elizabeth McRae, Christine McIntosh, Arline Croft, Frances English, and Kathleen Veitch are doing general duty in the Neurological Institute.

McGill School for Graduate Nurses:

At a recent meeting of the Alumnae Association the speaker of the evening was Mrs. T. H. Manning who gave an interesting talk on "Two and a half years with the British-Canadian Arctic Expedition". Recent visitors to the School included Nursing Sister Edith Weston who is serving with the R.C.A.F. Nursing Division in Western Canada, and Nursing Sister Alice Palmquist, R.C.N.N.S. en route to her home in the West on leave.

QUEBEC CITY:

Jeffery Hale's Hospital:

The following have recently accepted positions: Peggy Turner, as industrial nurse with the Aluminum Company, Shawinigan Falls; Gwen Bishop, with the staff of the Immigration Hospital in Quebec; M. Meyers, E. Coull, V. Hopper, M. Parks and B. MacKinnon, on general duty at J.H.H.; A. Marsh, as supervisor of the women's ward and the private floor. John Warren and M. Shannon have joined the Nursing Service of the R.C.A.M.C.

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Rationing is in the air (and alas! in the Journal) these bright Spring days . . . and it looks as though we may have to do without quite a lot of things we once thought indispensable . . . If ever the glad day comes . . . when we can carry home a whole pound of butter . . . we shall carefully place it in the refrigerator . . . and take it out on Sundays just to make sure it is still there . . . Some fine day . . . when the lights go on again all over the world . . . we are going to visit a little shop . . . now closed for the duration . . . and ask for a packet of Smoky Blend tea . . . then we shall measure out a heaping spoonful, brew it carefully and sip it delicately out of our best china cup . . . About that time we also expect to tell our butcher . . . quietly but firmly . . . that we never did care for pot roast . . . but will take a nice tender beefsteak, a little on the thick side . . . and if we need ten pounds of potatoes, three cans of soup, a bundle of rhubarb, half a dozen eggs and a few oranges . . . we shall not be willing to lug them home in a horrid paper shopping bag as we do now . . . a bright lad will once more bring them right to our door . . . At least we hope he will . . . although we sometimes wonder whether those comfortable pre-war days will ever come back in our time . . . perhaps it will be good for our flabby moral fibre if they don't . . . After this horrid display of greed in the matter of food . . . we had better hasten to add that we are prepared to adopt a more Spartan attitude when it comes to clothing . . . If and when we are told to wear the same hat for three years . . . we shall quote from yet another popular song . . . and say that "we've done it before and we can do it again" . . . After all, the English are facing up to it and so can we . . . If you remember what the hardier variety of British hat looks like even when brand new . . . and before the wind and rain have gone to work on it . . . you will have a faint idea of its grisly aspect at the end of the third winter . . . when the elements have done their worst . . . Yet nothing can break the spirit of these dauntless islanders . . . they just put the old hat on . . . pull it down firmly in front . . . turn it up behind . . . and sally forth on their lawful occasions . . . After casual inspection of the wilder type of spring millinery . . . now blossoming out in our shop windows . . . we suspect that as usual the British are right . . . We couldn't wear some of those hats for three years . . . in fact most of them we couldn't wear at all . . . —*E.J.*

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Okanagan District

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MANITOBA

Manitoba Association of Registered Nurses

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NEW BRUNSWICK

New Brunswick Association of Registered Nurses

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Registered Nurses Association of Nova Scotia

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ONTARIO

Registered Nurses Association of Ontario

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PRINCE EDWARD ISLAND

Prince Edward Island Registered Nurses Association

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Association of Registered Nurses of the Province of Quebec (Incorporated, 1920)

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Alumnae Associations

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MANITOBA

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NEW BRUNSWICK

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A.A., Glace Bay General Hospital, Glace Bay

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A.A., Brantford General Hospital, Brantford

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A.A., Public General Hospital, Chatham

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A.A., Cornwall General Hospital, Cornwall

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A.A., Galt Hospital, Galt

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A.A., Guelph General Hospital, Guelph

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